UNDERSTANDING THE CAUSES AND REMEDIES OF COMPASSION FATIGUE AND BURNOUT AMONG HOSPICE WORKERS

Jerome G. Weaver

BA, University of Cincinnati, 1993
MDiv, Harvard Divinity School, 1996

Mentors

Elvin Sadler, DMin
Willie Eugene Marshall, DMin

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Jerome G. Weaver

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Elvin Sadler, DMin
Willie Eugene Marshall, DMin

Date: 4/30/2020

Approved:

Faculty Mentor:

Associate Dean of Doctoral Studies:

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ABSTRACT

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The context is Vitas Healthcare the context in Cincinnati, Ohio. The problem is the company's lack of support for what appears to be work related compassion fatigue and burnout among hospice workers. If the developed curriculum was implemented, then participants would have an increased understanding of compassion fatigue and burnout. The implemented curriculum raised awareness through a six-week series of classes. Assessments included pre and post surveys, group discussions and exit interviews. Results showed that all nine participants showed signs of compassion fatigue or burnout and exhibited interests in engaging self-help strategies.

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joy, to the only wise God our Savior, be glory and majesty, dominion power, both now and ever." Amen.

DEDICATION

This work is dedicated three-fold. First it is dedicated to my parents David Weaver and Gwendolyn Jewell Weaver, especially my mother, who died at the young age of twenty-one giving birth to me. I hope and pray that my life and journey has sufficiently honored your memory. Second, I dedicate this to my wife, Chantal. Your love, commitment, prayers, and sacrifices for the Lord, our family, and our ministry are appreciated beyond what mere words can adequately express. Finally, this work is dedicated to all those compassionate souls who work in hospice. Please know that your labor is never is vain; and that God is always ready and willing to replenish and renew you especially during the tough times.

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INTRODUCTION

This project addresses the need to raise awareness about compassion fatigue and burnout and the importance of cultivating a lifestyle of effective self-care. The primary concern is that employees at Vitas Healthcare in Cincinnati, Ohio are not getting the kind of psycho-social, spiritual or emotional support needed to maintain a healthy balanced life and to continue to render quality care to patients and families. This project implemented a self-developed curriculum seeking to raise awareness about the risks and effects of compassion fatigue and burnout. The hypothesis was if the self-developed curriculum was implemented, then Vitas employees would be more aware of the risks of compassion fatigue and burnout and more motivated towards self-care initiatives. The project met with mixed results.

Three learning goals were identified to be met by the curriculum. First, participants gained insight and understanding into the nature and causes of compassion fatigue and burnout. During classes two and three of the workshop, students were presented with a thorough overview of the philosophical and theoretical bases of the subject beginning with a definition of the words compassion, and burnout and compassion fatigue. Compassion is a compound word comprised of the Latin root "passio," meaning "to suffer, and the prefix "com" which means "together.[1] Thus the

[1] Merriam Webster, "compassion," last modified March 22, 2019, accessed March 25, 2019, https://www.merriam-webster.com/dictionary/compassion.

word compassion literally means "to suffer together." Researchers agree that it is the feeling that arises when one is confronted with another's suffering and feels motivated or inspired to take actions to relieve that suffering. Psychologist, Dacher Keltner, of the University of California in Berkeley observes that as a concept compassion is often identified as synonymous to empathy or altruism.[2] While these concepts are related, they are not the same. Empathy refers more generally to our ability to take the perspective of and or feel the emotions of another person. Compassion refers to the mediating or helpful actions that occur as a result of empathetic feelings. Kelther writes, "Altruism, in turn, is the kind, selfless behavior often prompted by feelings of compassion, though one can feel compassion without acting on it, and altruism isn't always motivated by compassion."[3] Essentially, compassion is not simply feeling empathy or having altruistic feeling towards someone suffering, it is the desire, the passion to do something or to alleviate that suffering. This is very similar to the "sense of calling" that leads individuals to careers in the "helping" field.

Further, burnout relates to feelings of hopelessness, work-related problems, lack of support in the workplace, and a questioning of the efficacy of one's efforts. It has a slow onset and is primarily the result of long-term work-related issues. Compassion fatigue on the other hand, is the result of secondary exposure to traumatic events. Its symptoms can have a rapid onset and may be related to one particular event or to

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[2] Dacher Keltner, "Compassion Define," The Greater Good Science Center, accessed March 25, 2019, https://greatergood.berkeley.edu/topic/compassion/definition.

[3] Keltner, "Compassion Define," accessed March 25, 2019, https://greatergood.berkeley.edu/topic/compassion/definition.

prolonged exposure to traumatic stories. Burnout can affect anyone in any field, compassion primarily affects those whose work involves help others.

Psychologist Charles Figley's theory of compassion fatigue was used to gain insights into the job-related hazards of hospice work. Accordingly, prolonged exposure to human suffering can have inevitable effects on one's psychological, emotional, spiritual and physical well-being with some effective means of self-care. Figley (et. al) outlined what they see as theoretical factors that are instrumental in identifying and addressing the issue compassion fatigue which they refer to as secondary traumatic stress (STS). They involve the following nine factors:

1. STS is a highly complex and often unavoidable experience when working with the suffering or those who study them; or through records of traumatic experiences.

2. STS is most often present when a worker is exposed to a given dosage of evocative reality. This dosage varies from person to person: From direct contact and discussion with the traumatized to videotapes of interviews with the traumatized, all the way to reviewing written materials without photographs written by another.

3. STS is elevated when the worker generates the necessary empathic response to do their job of helping to understand and help the traumatized.

4. STS is elevated when the worker must compartmentalize the stress reactions to the evocative reality (direct contact, phone, or records).

5. STS is elevated where there is prolonged exposure to evocative materials in the course of doing their job.

6. STS is elevated when prior traumatic events are remembered.

7. STS is lowered when the worker experiences incidents of compassion stress satisfaction that increases a sense of worth and purpose.

8. STS is lowered when the worker experiences the social support from fellow workers, management, and the institution generally.

9. STS is directly related to the level of compassion fatigue resilience (CFR) but affected also by other life demands outside of work.[4]

The second learner goal for this project was that participants will be able to personally identify with course material relevant to their own roles as hospice workers. This was especially addressed during the fourth class of the workshop. Here participants were asked to personally reflect on materials covered during the two prior classes. Next, two of the participants were asked to share their personal stories about struggles they were having as related to work (as shared with me personally earlier). Their stories really "hit home" or resonated with others. They transformed the class into a support group during which people became very emotional. This experience became very cathartic for all gathered as the group quite visibly wrestled with the materials presented and their own real-life stressors. More evidence that the second learner goal was met also came out of the post-class interviews. Eight of the nine participants admitted to experiencing two to three ongoing or occasional job-related adverse maladies. These included: depression, irritability, insomnia, guilt, intrusive thoughts, and anxiety; all of which are job related psycho-emotional occupational hazards as discussed in classes two and three.

Third, participants gained an increased awareness of the importance of maintaining good personal mental, emotional, social, and spiritual hygiene or self-care. Classes five and six specifically addressed the need for self-care from the Buddhist and clinical perspective. The presenters engaged the group in very interactive ways which

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[4] Marné Ludick and Charles R. Figley, "Toward a Mechanism for Secondary Trauma Induction and Reduction: Reimagining a Theory of Secondary Traumatic Stress," *Traumatology* 23, no. 1 (March 1, 2017): 112-123, accessed March 2, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=4&sid=dd36d761-bcdd-471d-acdc-198b3c2ec4a1%40sdc-v-sessmgr04&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsovi.10.1037.trm0000096&db=edsovi.

created great dialogue during which participants gained increased awareness of compassion fatigue, burnout, and self-care. One participant commented that "I knew something was wrong with me, but I couldn't name. This class has helped me name it." Another participant commented "it's good to know that I'm not alone with these feelings. I'm not the only one." Someone else commented, "now that we know all this, what do we do? What are we supposed to do with all this information? In fact, question number 8a of the exit interview asked participants what advice they would offer someone new to hospice. This question was specifically asked to address the third learning goal. All nine participants mentioned something about the importance of taking care of themselves. This doctoral dissertation will be briefly summarized below.

Chapter one involves a ministry focus chapter, which highlights my personal life's struggles with the issue of abandonment. The sense of abandonment led to a whole lot of emotional, psychological, and spiritual pain and suffering. Being the product of an unhealthy and abusive environment sensitized me to the needs and concerns of vulnerable and or neglected or hurting people. It tends to taint the way you view or engage the world. I have always had a strong desire to help others who may struggle with abandonment issues. This led me to look at what I perceive as potential abandonment issue in my current context Vitas Health where employer/employee relations were concerned.

Chapter two is the first of four foundation chapters. This is the biblical foundation chapter, which focuses on Mark 15:34. The chapter presents an exegetical analysis of Jesus' cry of dereliction. Here we see Jesus' human nature, the Son of Man, not His divine self, the Son of God, lamenting the horrors and atrocities of the cross. It

was God's compassion, love, and empathy that motivated Him to act on behalf of lost and hurting people. It was His exposure to humanity's suffering under the weight of sin that brought Him to the cross. In isolation and aloneness, in the darkness, and in the dying of the cross, Jesus' human nature let out a gut-wrenching cry, "My God, My God, why hast Thou forsaken me?" This is a perfect example of the pain and anguish of abandonment; suffered not just on the cross but on the hearts and minds of all those courageous men and women since then who have dared to answer to call to render selfless service to hurting people.

In chapter three, we examined the historical narrative of canonized nineteenth century Roman Catholic Priest, Damien de Veuster, who left his home in Tremeloo Belgium to become a missionary to a leper's colony on the Hawaiian Island of Kalaupapa. Here he willingly practiced what Dietrich Bonhoeffer would later coin Kenosis or "emptying of oneself on behalf of others." He committed himself exclusively to providing compassionate care for the ravaged and dying lepers of the island. He identified with them in every way possible, giving no concern to his own health or exposure to contagion. According to biographer John Milsome, "He was their champion: he fought ceaselessly for their rights. He was their father and friend: he was totally available to help all their needs, from lifting broken spirits to bandaging leprous sores, from organizing musical and sporting events to making coffins and digging graves." Milsome pointed out that Damien was no social worker pretending to be a priest, he was a priest trying to meet both the spiritual and material needs of vulnerable people. All the while, his personal needs for collegiality, friendship, and someone to pray with were denied because of the government-imposed banishment. This eventually took its toll on

Damien and started impacting his judgement and behaviors. He became increasingly cynical and oppositional especially with the religious and business elites. It could be argued that this may have been a manifestation of compassion fatigue or burnout for which he never got treatment. Damien died from leprosy at the young age of forty-nine. Some clinicians refer to this at "the cost of caring."

In chapter four, we learned from Dietrich Bonhoeffer's theological framework that all who work in ministry or in compassionate care for others have a special sense of call to it. For him, Christ is at the center of everything and that to be a Christian, a church or a servant, literally requires self-abandonment for the Kingdom of God (Matt. 10:37, 16:24-25, and 1 Ptr. 2:21). Bonhoeffer believed that Christians were called to empty themselves before God in and through Christ Jesus in service to others; that God has a specific plan for all believers which requires complete submission via faith and obedience. This implies a willingness to meet real people where they are in the real world with a Christocentric motive of impacting their lives. This is the essence of compassion ate care. Dr. Emma Sepala of Stanford University is in agreement; and she described compassion as the emotional response to perceived suffering accompanied by an authentic desire to help.

Chapter five looked at the field of psychology to seek insight from psychologist Charles Figley's Theory of compassion fatigue. Here we learned that compassion fatigue is a construct characterized by deep physical and spiritual exhaustion accompanied by acute emotional pain. The consequences of which might have been not only evidenced in my life, but in Jesus' cry of dereliction, in the lives of Fr. Damien de Veuster and

Dietrich Bonhoeffer, and among and those who serve in the healthcare industry. It was certainly evidenced among the participants of this dissertation project.

Chapter six involved a thorough review of survey and interview data, as well as, a review of research findings and conclusions. While the scales used for this project yield mix results, the classroom experiences, exit interviews, and contextual outcomes proved that all three of the project's learning objectives were met.

CHAPTER ONE

MINISTRY FOCUS

One of the greatest and most prevalent truths throughout human history is that people matter. They are important. People matter because they matter to God. The Bible says that, "God so loved the world that he gave his only begotten Son that whosoever believes in Him should not parish but should have eternal life (Jn. 3:16). People are so important to God that He willingly, without hesitation, paid the ultimate price for our ransom. The more pressing question pertains to humanity itself. As those formed and fashioned in the Imago Dei, the very image of God, does our level concern, compassion, and love for one another adequately reflect His? Abandonment theorist would argue the contrary. The primary focus of this doctoral project is the issue of abandonment as it seems to have been a dominate theme and factor through my life's struggles. The primary interest guiding this inquiry involves an exploration into nature of human and the notion of suffering. How do hurting people find healing and wholeness, especially suffering with abandonment issues?

Abandonment often leaves a lifetime of emotional, spiritual and social challenges for its victims, which is not always easily managed. According the *Cambridge Dictionary*, abandonment is, "the act of leaving someone or something or of ending or

stopping something, usually forever."[1] Author Ann Pietrianelo, writes, "Anyone can develop a fear of abandonment. It can be rooted in a traumatic experience you had as a child or as a distressing relationship in adulthood."[2] Abandonment has been likened to adulthood disorders like low self-esteem, avoidant personality and borderline personality disorder. In fact, it is very common for adult survivors of some form of childhood abandonment to experience long term effects such as: trust issues, anger issues, mood swings, codependency, fear of intimacy, anxiety disorders, panic disorders, and depression. Therefore, the purpose of this chapter is to explore the possible ways that extra-biblical and clinical ideologies can converge in effectuating meaningful assurances and therapeutic supports to vulnerable or suffering people.

The original context for this inquiry was the Mt. Zion Church of Connersville, Indiana. Then the focus was on abandonment as a result of derelict pastoral leadership. However, during my second year in this Doctor of Ministry program, my ten-year tenure with Mt. Zion (2008-2018) came to an end, which necessitated a change of context. The current context is Vitas Healthcare, a national provider of hospice care. Here the focus is on possible institutional abandonment, not of patients, but of employees themselves. Many employees are subjected to or bombarded by, numerous patient and family care related daily stressors. This could potentially put them at risk for compassion fatigue or burnout.

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[1] Cambridge Online Dictionary, "Abandonment," accessed March 30, 2019, https://dictionary.cambridge.org/us/.

[2] Ann Pietrangelo and Timothy J. Legg, "What Is Fear of Abandonment, and Can It Be Treated?" Healthline Newsletter, February 13, 2019, 1, accessed March 30, 2019, https://www.healthline.com/health/fear-of-abandonment.

I begin with a brief review of my personal narrative as it applies to the issue of abandonment followed by a summation of my ministerial and profession journey. Next, I look for the synergy between the two in order to draw a realistic and workable conclusion which can appropriate in my current ministry context throughout this doctoral project.

Personally, I am all too familiar with issues like these from my own struggles with abandonment. My live was filled with trauma from the start. My mother was gravely injured during my birthing process and died six months later. This initiated a life-long journey of painful and traumatic experiences, often at the hands of those adults who should have been nurturers and protectors. As a child, I suffered rejection, mental and emotional abandonment at the hands of my father, grandfather, and uncles. When I was ten years old my maternal grandfather, while intoxicated, actually declared his hatred of me stating that "you're the reason my daughter is dead now." Through my adolescence years, my father became verbally, emotionally, and physically abusive. Yet, my siblings and I were afraid to tell anyone about our home life because we were constantly warned not to "air our family's dirty laundry in public." This kind of victimization resulted in a life-long struggle with issues like self-worth, trust, and human connectedness, especially with males, and a strong desire to heal and to help others suffering with abandonment related issues heal as well.

From the time I graduated high school, even before my conversion experience, my employment history and career path have always involved ministering to the needs of people. Perhaps, this is because I subconsciously identified with human vulnerability and woundedness. Over the years, my various roles included being: an orderly in a convalescent center (two years), a counselor/manager with the (then called) Mentally

Retarded/Developmentally Disabled population (nine years), a chaplain intern in a private psychiatric hospital (two years), a staff counselor in a private psychiatric respite (two years), a youth pastor (five years), a children services worker (two years), manager in a homeless shelter (one year) and hospice chaplain (sixteen years), bereavement services manager (two years), and pastor (ten years). My undergraduate degree is in psychology. I was headed towards a Ph.D. in Clinical Psychology before receiving a call to ministry and going to Divinity School and launching into a career in ministry.

One of the main lessons learned over the years of working with many different people, each with their own unique story, is that everyone is dealing with something. I have also learned that the universality of sin as taught in scripture, or by what St. Augustine coined the "Original Sin," had detrimental effects on the collective human psyche.[3] In fact, my Master's Thesis was on this very subject, "Sin, Society and the Pastoral Counselor." Much research has been devoted to finding connections between sin and psychopathology. It seems that the "fallen nature" of humanity with its accompanying negative and maladaptive behavioral tendencies locks humanity into an unending cycle of dysfunction that can only be remedied by a relationship with Christ.

As learned in the theological chapter, effective ministerial interventions should seek, not to judge or condemn individuals, but to show empathy and compassion, to educate, and to offer guidance. It is a pedagogical approach to transformation that starts where people actually are with the goal of helping them find their purposes in Christ Jesus. Jesus encountered such a family in the Gospel of Mark 9:14-29, a father whose son had long been tormented by a demon spirit. Any parent knows that when your child

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[3] Alfred T. Overstreet, "Are Men Born Sinners? The Myth of the Original Sin," Gospel Truth, accessed December 5, 2017, https://gospel truth.net/menbornsinners/mbsindex.htm.

goes through adversity, your whole household goes through with them. Jesus' answer was to take authority over the devil, get down into the boy's misery with him, take him by the hand, and lead him out. He then taught the father, thus the family, how to effectively maintain. I believe that today's churches should adopt a similar strategy to help minister to the needs of vulnerable and hurting people. While hospice companies operate under strict regulations and guideline concerning ecumenism in spiritual care, no one can restrain the Holy Spirit's ability to touch lives through the ministry of presence and compassionate care.

Further, as indicated in my spiritual autobiography, this ministerial praxis is personal to me. The pain, sorrow, anger and frustration of having grown up deeply immersed in dysfunction is still very vivid to me. It has now been twenty years since my father died; and I finally brought closure to that seemingly endless and very difficult chapter of my life. My wife and I are in our twenty-ninth year of marriage. We have two adult sons. I made each of them a vow upon holding them in my arms for the very first time as infants. I promised, by the grace and help of God almighty, to always be there for them, and to be the best father humanly possible. Today, I can honestly say that Chantal, my wife, and I gave it all we had. It was not easy. Parenting is hard work. There were many times when we felt that we were in over our heads. We both came from dysfunctional backgrounds with very limited outside supports. We made a lot of mistakes trying to establish a "good" home life for our family. Yet, we loved the Lord, loved one another, we were committed to our children, and determined to hold the family together. Like any other family, we are not perfect, we had and have our trials, but by God's grace we remain a very close and tight knit family. Thus, the origin of my

ministerial praxis is somewhat a "mixed bag." It is based on the lessons gleaned from pains of childhood, the clinical competencies and sensitivities learned from a career of working with people, and twenty-nine years of insights and wisdom formed in the intricacies, and challenges of just being in a family. It comes from the faith accrued over a lifetime of seeing the wonder-working power of God take a bunch of disjoined, dissimilar and disenfranchised pieces and make them into something glorious; just as he did with Ezekiel in the valley of dry bones. I combined these experiences into a more holistic view of ministry that meets the spiritual, emotional, psychological, and social needs of hurting or lost people, in and outside the church. This is the faith that has led me throughout my life and that I brought to my current context, Vitas Healthcare.

Vitas is a national provider of hospice care for terminally patients and families. It is headquartered in Miami Florida with sixty programs located in forty-nine cities across the country. It provides palliative care services and interdisciplinary support for approximately 20,000 terminally ill patients and their families daily. Since 1978, Vitas has been the nation's leading provider of these services. It is the reputed "gold standard" of hospice care in America. I have been employed for Vitas for the past nineteen years as a chaplain, community liaison and now bereavement services manager for Cincinnati and Dayton, Ohio programs. From its beginning, Vitas was on the cutting edge of the hospice an innovative trail blazer in the field of hospice care.

The modern hospice movement began on July 24, 1967 when the late Dame Cicley Saunders founded St. Christopher's Hospice in London, England.[4] Saunders began her career as a social worker but through her experiences with patients and families

[4] St. Joseph's Hospice, "Our History," accessed August 15, 2018, http://www.stjh.org.uk/about-us/our-history.

grew to foster a deep sensitivity to, and respect for the needs of the terminally ill. She was particularly critical of traditional healthcare practices toward dying patients. She was concerned that patients and families were subjected to inadequate care which denied them the dignity of holistic treatment throughout the dying process. They were not getting truthful diagnoses, or effective pain management. Their emotional, social and spiritual needs were being ignored.

Underlying her beliefs was her very strong faith in God. Saunders was a committed Christian whose faith weighed heavily in her sense of calling to healthcare. Desiring a stronger voice as an advocate for the terminally ill, she returned to school becoming both a nurse and a medical doctor. In his article, "Religion, Medicine, and Community in the Early Origins of St. Christopher's Hospice," Dr. David Clark writes, "She studied medicine as a third profession specifically to do something about the problem of pain in patients dying of cancer."[5]

Saunders expanded healthcare's understanding of pain to include spiritual, and emotional factors. She revolutionized end-of-life care by introducing the idea of an interdisciplinary team approach. As mentioned above, the focus of hospice care is palliative care, otherwise known as comfort-care. Unlike the more traditional curative form of patient care which focuses primarily on curing some chronic illness, palliative care's primary emphasis is symptom management. That is, hospice concerns itself with the comfort level of the patient and family so as to offer as much comfort, peace, and

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[5] David Clark, "Religion, Medicine, and Community in the Early Origins of St. Christopher's Hospice," *Journal of Palliative Medicine* 4, no. 3 (2001): 353-360, accessed August 13, 2018, https://eds.b.ebscohost.com/eds/detail/detail?vid=2&sid=b12600d9-3053-4ed3-94e6-df19dfa1ab14%40sessionmgr104&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=RN102659508&db=edsbl.

dignity as possible. For Saunders, the whole philosophy of hospice care is best captured in the following quote, "You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die."[6]

In 1971, Saunders was invited to lecture at Yale University on Palliative Care to terminally ill patients and their families. These classes strongly influenced the initiation of the American hospice movement in two ways. First, it led to the opening of America's first hospice in Connecticut in 1974. Second, among Saunders' students was a Methodist minister name Hugh Westbrook and an oncology nurse named Esther Colliflower. The two would eventually partner in 1978 to start Hospice Care Incorporated, eventually Vitas Innovative Hospice.

The name Vitas is derived from a Latin word meaning "life." It symbolizes Vitas' goal of preserving the quality of life for terminally ill patients. Together Westbrook and Saunders were able to secure the nation's first hospice licensure law in Florida in 1979. Two years later, Hugh was very instrumental in getting the national Hospice Medicare Act passed in Congress in 1982. This made hospice services a national Medicare benefit. Shortly thereafter, Hugh changed the company's 501(c)(3) status to a for-profit reportedly to secure its sustainability and growth. Under Hugh and Esther's leadership, Vitas grew into the nation's leading and largest provider of hospice care. Trying to adhere to the ideas and values of Dame Saunders, Westbrook and Colliflower sought to maintain exceptional palliative services that affirmed the values, dignity and needs of patients, families and employees alike.

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[6] "History of Hospice: A Historic Perspective," National Hospice and Palliative Care Organization, accessed September 17, 2018, http://www.nhpco.org/history-hospice-care.

Vitas' mission statement is as follows: "We are a growing family of hospices providing the highest quality human services, products, and case management to terminally ill and other appropriate patients and their families with measurable advantages for the patient, the family, the medical community, the employee and the stockholder."[7] Vitas operates under four core values: 1) Patients and families come first; 2) We take care of each other; 3) I do my best today and even better tomorrow; and 4) I am proud to make a difference. The company placed great emphasis on both the patient/family and employee experience. In 1995 Vitas opened its Cincinnati program by acquiring a smaller hospice called the Hospice of the Miami Valley. I was hired by Vitas as a chaplain on March 3, 2002 and found it to be a very blessed, reassuring and supportive place to work. At risk of redundancy, it felt like a real "family type environment." At the time there were only three or four competitors in town, now there are over twenty.

I will never forget the day the company's whole culture felt as if it changed. It was a warm summer day in 2004. I was in the field as usual visiting with patients and families when I received a page (yes page) over my beeper. It informed field staff of an emergency meeting to be held at the office that afternoon everyone was expected to be there (mandatory). We were then informed that after twenty-four-years of exceptional leadership, Vitas was sold and about to go public. They were sold to a Cincinnati based company called Chemed for $400 million dollars. Chemed reportedly "makes business

[7] Ariel Schmid, email message to author, June 1, 2018.

by purchasing, operating, and divesting in various subsidiaries (?)."[8] They saw Vitas as a high-potential diversification to their portfolio.

The Cincinnati program is the so-called "mother ship" of the three Ohio based Vitas cites (Dayton, and Columbus) in that they all operate under Cincinnati's license. Cincinnati is the largest of all three Ohio programs. Cincinnati is also my base. However, I also manage Dayton's bereavement program and work out of the Dayton office once a week. The focus of this project is the Cincinnati program.

Vitas Cincinnati is headquartered in Mason, Ohio, a Cincinnati suburb located in Hamilton County. It provides hospice services in eight counties throughout South Eastern Ohio for an average of 350-400 patients and families daily. The vast majority of Vitas Cincinnati's patients come from Hamilton County, therefore, it will be the focus of this analysis.

As of 2016 Hamilton County's population size was 809,099 with a "very high" per square mile density, 1,986 people. Racially it is 65.5%, white, 25.6% black, 3.1% Hispanic, 2.6% Asian, and 2.7% two or more races. Hamilton County residents are 48.2 % male and 51.8% are female. The median age is thirty-seven with 23.2% of the county under eighteen years of age and 13.3% over sixty-five. Approximately, 44, 974 Hamilton County residents are veterans. In 2010, 52.5% of them reported having a religious affiliation while 47.5% report none. The average household size is two people. The median household income is $53,299 with approximately 15.8% of Hamilton County residents living beneath the poverty of line. The cost of living index is 89.9% and unemployment is at 4%. The estimated property rate is $150,000. The county's

[8] Ariel Schmid, email message to author, June 1, 2018.

graduation rates are as follows: high school (90.1%), associate degree (18.4%) bachelor degree (49.6%), and master's degree (22.4%). These stats also hold true for both Vitas' patients and employee base. In terms of terminal illnesses, the leading causes of death in Hamilton County, Ohio are dementia, lung cancer, heart disease, acute myocardial infarction (AMI, heart attack) and chronic obstructive pulmonary disease (COPD). There are on average eleven hospice appropriate deaths a day or 330 monthly which never receive these services. There are basically two primary reasons for this phenomenon, fear and lack of information.

Many people are simply afraid of the very idea of hospice care. The very word hospice for them conjures up images of the "Grim Reaper." This mindset comes from generations of the general public's fascination and even intimidation with the idea of death and dying. Other people's fears are strongly tied to their belief system. Some see accepting or engaging hospice as a sign of insufficient faith or trust in the healing powers of God. Thus, accepting hospice for them is synonymous to spiritual abandonment. Yet for other, particularly African Americans and other minorities, there is an overall since of distrust of the medical establishment. This traces all the way back to incidents like the infamous Tuskegee Experiment where 399 black men were deliberately infected with syphilis and left untreated to monitor the disease' impact on the human body.[9]

A second reason why so many people die without hospice services is due lack of information. The patient and their families never received counsel or education about the relevancy of hospice care for these suffers. Further, all too often there are inherent systemic or policy issues that sometimes seem to work against the best interest of the

[9] Centers for Disease Control and Prevention, "The Tuskegee Timeline," accessed April 7, 2020, https://www.cdc.gov/tuskegee/timeline.htm.

patient and families. Often referral sources are directly tied to private practices, hospitals, long-term or extended care facilities themselves. Although many have a moral and legal obligation to educate and inform patients and families of their treatment options, this is often tainted by the marketing process. Unfortunately, the company that gets the most referrals is often dependent upon personal relationships and perks offered. Finally, many physicians still personally struggle with the idea of hospice. They take the Hippocratic Oath which obligates them to do everything possible to help their patients get better. Knowing where to essentially draw the line between their best efforts and the inevitable declining process of a terminal illness is simply difficult for them to come to terms with. Often they wait too late to mail hospice referrals which only hurts the patients and families. It hinders the hospice team's ability to establish trust and report with the family which diminishes the efficacy of services rendered.

Nonetheless, Vitas Cincinnati's goal is to make sure that all patients and families are properly educated and informed about viability and accessibility of these services. To be sure, Vitas invests a great deal of emphasis and resources into living up to its first value, "Patients and families come first." Through their marketing department they do a good job at reaching out to all of Cincinnati's demographic groups with education and community engagement programing. However, the question being raised in this project is how well it lives up to its second value, "we take care of each other?" This is important because it seems that the remaining two value statements, "I'll do my best today and even better tomorrow," and I'm proud to make a difference," are dependent upon the employee's perception of how appreciated, affirmed and support he or she feels.

There are basically two types of caregivers with Vitas, those who work on an interdisciplinary team providing what we call a "Routine Level of Care," and those who work on the "Continuous Care Team." With a routine level of care, patients and families receive the full continuum of hospice care in whatever context he or she calls "home." Home is the place which the patient resides. It could be a nursing home, public housing, or personal residence among other possibilities. Under the routine level of care, patients receive at least two nurse's visits, two to three CNA visits weekly. They receive psychosocial support from a social worker and chaplain once monthly or as needed. They also receive visits from therapists, volunteers and physicians as need. The team's primary responsibility is to assure effective symptom management so as to maximize the patient's levels of comfort and well-being. This means monitoring and managing pain issues via medications, therapy, securing needed home medical equipment (HME), and maximizes the patient sense of comfort and assurance via clinical interventions, chaplains and social workers. Assurance comes via providing the social, practical, physical, emotional and spiritual services deemed helpful or meaningful to the patient and family. On a daily basis, hospice workers meet families in the realities of terminal illness' difficult, complex, and often unpredictable realities with compassion, kindness, and an ability to help bring meaningful closure to life long and centralized relationships.

The other level of care for hospice workers is called continuous care. Continuous care is around the clock one-on-one care for patients whose status suddenly changed becoming more tenuous or critical. The nurses and aides who work in this department work in twelve-hour shifts. They work directly with patient and families in their own homes. Often when a patient's level of care changes from "routine" to "continuous care,"

patients are nearing transition. Many continuous care staffers report that these are some of the most emotionally difficult times to be with families. It seems as if they are left to be with the families during their most vulnerable and potentially erratic times, as death becomes increasingly more imminent. While, as nurses, their primary responsibility is for the patient, they often find themselves immersed in the varying emotional states, family dynamics, and situational complexities that accompany dying with little-to-no support from peers or the company. In fact, they are expected to be with the family during the initial waves of shock and grief at the time of death, which can get very difficult. They clean and prepare the body for the gathering family and funeral home. Nurses remain on the in the home until the body is removed. They then go to their cars, finish their paperwork, call the office to report the death and often get immediately dispatched to another family. Nurses are given no time to debrief. More times than not, no one even asks how they are doing. This is true for members of both routine care and continuous care teams.

This can be seen as a kind of organizational and institutional neglect, or abandonment of one of its most valuable resources, caregivers themselves. The research presented in this study will suggest that this is an industry-wide problem. Not enough is done across the healthcare industry to systematically or programmatically care for caregivers. This also holds true for the almost 13,000 men and women employed by Vitas and this makes them vulnerable to stress related illnesses like compassion fatigue and burnout. Dr. Charles Figley's model of compassion fatigue suggests that prolonged exposure to human suffering will have inevitable psychosocial and emotional occupational hazards of hospice workers. If Figley's theory is correct; then Vitas could

potentially have a significant number of distressed individuals in its ranks. Failure to implement effective means of employee support initiatives and or educational programming may very well constitute a kind of institutional abandonment. This not only affects the personal lives of employees but could also impact patient care and the company's overall viability.

Therefore, this inquiry will be specifically focus on the issue of hospice caregivers' risks for compassion fatigue and burnout. I will also look into what roles or responsibilities hospice or healthcare companies have in assuring psychosocial, emotional, and spiritual wellbeing of their staff. This is especially relevant where it applies to Vitas Cincinnati. I will utilize commonly used tools (scales and worksheets) from the field of sociology and psychology to assess the caregiver's levels of stress or satisfaction. This will be followed by a six-week curriculum on the subject matter. The class will be comprised of a cross-section of the various disciplines working out of the Cincinnati program. The worksheets and scales will be administered before and after the six-week classes. These will be followed by a one-to-one exit interview with each participant. My hypothesis will suggest that if project participants complete this six-week course, then they will be more aware of the importance of self-care. It is my hope that the insights gained from this study will help Vitas improve both its supports and retention of its employee base.

CHAPTER TWO

BIBLICAL FOUNDATIONS

Throughout history human beings have always been mystified by the phenomenon of death and dying. Many find its instantaneous and mysterious nature both intriguing and terrifying. This is especially true of human deaths. Even those who hold to strong faith and religious traditions are sometime taken aback by death. One is never more in touch with or sensitive to his or her own mortality and vulnerabilities than when confronted with the reality and apparent finality of dying. Even when expected, its arrival and the accompanying emotional responses can be powerful enough to "shake people to the core" and even alter the trajectory of their lives. Like birth, death really is one of life's greatest common denominators. We all come into this world with both an initiation and an expiration date. In his account of Jesus' death Mark describes a very inhumane and torturously violent crucifixion. Jesus hang slowly dying between "two thieves," from the "third hour" (9:00 a.m.) until the "ninth hour (3:00 p.m.). During that time, he was mocked, scoffed at, and ridiculed by the very people for whom he was in this predicament. Then at the sixth hour, Mark reports that darkness, came over the whole land for three hours (12:00 noon to 3:00 pm). Jesus then released a loud mornful cry, "Eloi, Eloi, lema sabachthani?" The translation of which is "My God, My God, why have you forsaken me?" The nature and subsequent impact of this cry has proven foundational throughout Christian history. Some scholars refer to this cry as an "epicenter" of

Christian salvation history.[1]" What does Jesus' final cry mean, and exactly what is it that Mark is communicating to his audience about Jesus and his death?

Many see in Jesus' cry a prayer of lament and dereliction, others the victory shout of a conquering king. This chapter will offer a thorough examination of this passage in hopes of arriving at a clearer understanding of its meaning and relevance to Christendom past and present. I believe that Jesus' cry on the cross was in fact an expression of the deep pains of abandonment. Therefore, valuable lessons can be drawn from His Calvary experience as we address some of the contemporary issues of abandonment related to grief and loss. The chapter begins with an exegesis of Mark 15:33-34, followed by an exegetical over-view of the "cry's" original source Psalm 22:2. Next this study will survey how these texts have been interpreted by competing scholastic schools of thought. Finally, an attempt will be made to appropriate lessons from the cross in addressing some of the emotional and relational problems and challenges of abandonment, grief and loss in the twenty-first century as it relates to this dissertation project.

Mark 15:25 informs us that it was 9:00 a.m. when they "crucified" Jesus on the hill called Golgotha, the "place of the skull." According to the ancient roman system of tracking time it was the "third hour" of the day. He hung impaled, beaten, and suffering for three hours. Then at the "sixth hour," or 12:00 noon a sudden and unanticipated darkness befalls "the whole earth." The Greek version of verse thirty-three is rendered, "Καὶ γενομένης ὥρας ἕκτης σκότος ἐγένετο ἐφ' ὅλην τὴν γῆν ἕως ὥρας ἐνάτης."[2] It

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[1] Michael Jinkins and Stephen Breck Reid, "God's Forsakenness: The Cry of Dereliction as an Utterance within the Trinity," *Horizons in Biblical Theology* 19, no. 1 (June 1997): 33-57, accessed May 1, 2018, https://web-a-ebscohost-com.utsdayton.idm.oclc.org/.

[2] BibleHub, "Mark 15:33," accessed April 15, 2018, http://biblehub.com/interlinear/mark/15-33.htm.

translates, "And when the sixth hour was come, there was darkness over the whole land until the ninth hour." Of interest here is the word "skotos" or darkness and the phrase "egeneto eph holen ten gen," or "over all the land." Skotos is a nominative neuter singular noun. According to *Strong's Concordance* it means either physical or moral darkness.[3] The Lexicon defines it as the darkness of chaos, or nonexistence, or the place of punishment far removed from.[4] Figuratively, it symbolizes the principle of sin with its certain results, divine judgement or punishment. It is used thirty-one times in the Bible. In each case it refers to spiritual or moral depravity which has the potential of isolating individuals from their divine source, God. Examples of such verses include "The eye is the lamp of the body. If your eyes are healthy, your whole body will be full of light. But if your eyes are unhealthy, your whole body will be full of darkness. If then the light within you is darkness, how great is that darkness!" (Matt. 6:22-23). "Do not be yoked together with unbelievers. For what do righteousness and wickedness have in common? Or what fellowship can light have with darkness?" (2 Cor. 6:14). "For you were once darkness, but now you are light in the Lord. Live as children of light (for the fruit of the light consists in all goodness, righteousness and truth) and find out what pleases the Lord. Have nothing to do with the fruitless deeds of darkness but expose them (Eph. 5:8-11)."

Further, Egeneto eph' holen ten gen suggests that this darkness suddenly appeared at 12:00 noon over "all the land." The Greek word for land is gen. According

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[3] James Strong, *Strong's Exhaustive Concordance: Complete and Unabridged Compact Edition* (Grand Rapids, MI: Baker Book House, 1983), 65.

[4] William Bauer, *A Greek-English Lexicon of the New Testament and Other Early Christian Literature* (Chicago, IL: The University of Chicago Press, 1979), 752.

to Strong's, it refers to either a part of, or the whole earth, land, ground or world. In other words, from about noon until 3:00 p.m. this isolating, morally depraved darkness fell upon the immediate region that Jesus was in or over the whole earth for a span of three hours. This seems to parallel another miraculous appearance of instantaneous darkness. It occurred in Exodus 10:21 as a part of God's efforts to liberate Israel from 400 years of Egyptian oppression. It was the ninth of ten plagues that God visited upon Egyptian through Moses to pressure Pharaoh into releasing the Israelites. The darkness was described as so thick it, "could be felt," covered Egypt for three days. The Hebrew word for darkness in Exodus 10:21 and 22 is חֹשֶׁךְ "choshek." It means or indicates darkness, misery, destruction, death, ignorance, obscurity or sorrow.[5] Basically, this is the result of Pharaoh's hard-hearted deviance against divine imperative. Choshek is used forty-seven times in the Old Testament and in each instance, it too refers to some kind of wickedness, disobedience and or divine judgment.[6] Thus, in both the Old and New Testaments darkness is usually used in a negative connotation in connection with sin, immorality, disobedience and judgement. Interestingly, the darkness miraculously appears and remains in place for three hours in the middle of the day culminating in Jesus' "loud cry" and death.

This mysterious darkness is the first of two of what Craig A. Evans in his commentary refers to as "preternatural events;[7]" the second being the tearing of the temple curtain in verse thirty-eight. A preternatural event according to *Webster's*

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[5] Strong, *Strong's Exhaustive Concordance,* 44.

[6] BibleHub, "Mark 15:33," accessed April 15, 2018, http://biblehub.com/interlinear/mark/15-33.htm.

[7] Craig A Evans, *Word Biblical Commentary*, vol. 34B (Nashville, TN: Thomas Nelson Publishers, 2001), 506.

Dictionary is one "existing outside of nature;" something inexplicable which exceeds natural order. However, some thinkers seek more rationalistic explanations for this darkness. Raymond E. Brown attributes the darkness to a solar eclipse, thus suggesting the date of the crucifixion to have been either "7 April 30 C.E. or 3 April 33" because of possible eclipses on or around those dates.[8] Other rationalistic explanations of the darkness have been advanced attributing it to other natural events like, "the effects of clouds, sirocco winds, or distant volcanic eruptions. However, scholars like Joel Marcus in the, *Anchor Yale Bible Commentary* refutes such claims on three grounds.[9] First, solar eclipses do not occur during Passover. Marcus writes, "as an explanation of the darkness at Jesus's death' this gloss [Brown's] fails, since a solar eclipse occurs when the moon is new, while at the beginning of Passover it is full."[10] His second point was much like what we witnessed at United Theological Seminary during the first semester intensive of the 2018-2019 school year, solar eclipses lasted for about eight minutes whereas the Markan darkness extends for three full hours. Marcus' third contention rests on the prior arguments of Erasmus and Calvin that an eclipse only covers a narrow strip of earth's land mass, while Mark's account says that the whole earth was engulfed in darkness. No, this three-hour preternatural event simply cannot be explained away as some scientific or natural phenomena.

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[8] Raymond E. Brown, *The Anchor Bible Library: Death of the Messiah from Gethsemane to the Grave; A Commentary on the Passion Narratives in the Four Gospels,* vol. 2 (New York, NY: DoubleDay, 1994), 1376.

[9] Joel Marcus, *The Anchor Yale Bible: Mark 8-16; A New Translation and Commentary* (New Haven, CT: Yale University, 2009), 1054.

[10] Marcus, *The Anchor Yale Bible,* 1054.

Marcus places the darkness in the larger historical and cultural context of ancient Jewish and Roman world where its presence usually accompanied the death of a great leader or god such as Julius Caesar, Alexander the Great, or the Greek god Romulus. For Christian traditions, Marcus sees the darkness as eschatological in character as established earlier with the "woes" of Jesus in Mark's gospel, 13:24 and in Exodus the tenth chapter. Other biblical texts where darkness tends to symbolize end-time judgment include Revelation 8:12; 9:12; and 16:10. However, for Marcus the eschatological interpretation of the Mark 15:33 text is best supported by the Old Testament Text Amos 8:9-10, which states:

> And it shall come to pass in that day, saith the Lord God, that I will cause the sun to go down at noon, I will darken the earth in the clear day: I will turn your feasts into mourning, and all your songs into lamentation; and I will bring up sackcloth upon all lions, and baldness upon every head, and I will make as the mourning for an only son, and the end thereof as a bitter day.

For three hours the earth was covered with darkness symbolizing the mourning and or judgement of God and setting the stage for Jesus' cry of dereliction in verse thirty-four. Marcus believes that like the Amos passage, Jesus's prayer in the Garden of Gethsemane, and this three-hour period of darkness are only indicative of the motive of lament and grieving that sets the stage for Jesus' cry of dereliction.

In the ninth hour, or at 3:00 p.m., verse thirty-four says that, "Jesus cried in a loud voice, Eloi Eloi, lema Sabacthani? which is, interpreted, My God, My God, why have you abandoned me?" The Greek rendition of this verse is as follows: "καὶ τῇ ἐνάτῃ ὥρᾳ ἐβόησεν ὁ Ἰησοῦς φωνῇ μεγάλῃ Ἐλωῒ Ἐλωῒ λαμὰ σαβαχθανεί; ὅ ἐστιν μεθερμηνευόμενον Ὁ Θεός μου ὁ Θεός μου, εἰς τί ἐγκατέλιπές με."[11] It is actually a

[11] BibleHub, "Mark 15:33," accessed April 15, 2018, http://biblehub.com/interlinear/mark/15-33.htm.

combination of Aramaic and Greek languages. Ἐλωΐ Ἐλωΐ λαμὰ σαβαχθανεί is written in Aramaic because it is the language believed to have been spoken by Jesus, and Ὁ Θεός μου ὁ Θεός μου, εἰς τί ἐγκατέλιπές με is the Greek translation. This is believed to be the oldest known tradition of Jesus' last spoken words.[12] Of special interest here is the Greek verb ἐγκατέλιπές or egkataleipó. According to Strong's it means, "to leave in the lurch, abandon (one who is in straits), desert; properly, left in a condition of lack (without); hence, to feel forsaken (helpless), like left in dire circumstances.[13]" The Lexicon defines it as to "leave behind" or to "forsake." Figuratively it means "to desert one who is in danger.[14]" Moreover, for the purposes of this chapter seven different biblical interpretations were used: *The New Jerusalem Bible, Today's New International Bible, The New Oxford Annotated Bible with the Apocrypha, The King James Bible, The New King James Bible, The Jerusalem Bible and the Common English Bible*. All of these include Jesus's cry in Mark 15:34, "Ὁ Θεός μου ὁ Θεός μου, εἰς τί ἐγκατέλιπές με;" My God, My God why hast thou forsaken me. In each of the above-mentioned translations verse thirty-four is the same for the most part. The only variation seems to be in the words used to translate the verb "egkataleipó." All but two of the translations above employed the word "forsaken" for the verb, *The Jerusalem Bible* (JB) and *The Common English Bible* (CEB). *The Jerusalem Bible* renders "egkataleipó" as "deserted" and the CEB renders it "left." It should be mentioned however, that all three of these words are mentioned in the Strong's and Lexicon's definitions. Further, they all seem to indicate

[12] Brown, *The Anchor Bible Library*, 1085.

[13] Strong, *Strong's Exhaustive Concordance*, 25.

[14] Bauer, *A Greek-English Lexicon*, 215.

that Jesus' cry of dereliction actually emanates from a deep sense of aloneness or separation from God. Essentially, Jesus is a kind of righteous sufferer channeling the same sense of anguish and remorse as that of his ancestor, King David, in Psalm the twenty second chapter, the original source of the cry of abandonment.

In Psalm 22:2 the psalmist cried out, "My God, My God why has thou forsaken me?" However, to understand the meaning of this cry one has to view it in the context of the whole Psalm. Psalm the twenty second chapter has been divided into three different forms: lament (v. 2-18), prayer (v. 19-22), and praise and thanksgiving (v. 23-32).[15] The first two verses offer deeper insight into the intensity and depth of the feelings of abandonment conveyed by the psalmist. In verse one, immediately following the cry of dereliction, through verse two reads, "and why are you so far from saving me and, from my roaring words. O my God, I cry by day and you do not answer; and by night and there is no rest for me." The Hebrew word for "far" is רָחוֹק or rachoq. It means "far off, abroad, long ago, to put, to remove, or a great while to come."[16] In this text it is used as an adjective to describe the great deal of space or distance between the psalmist and his primary source, God. In other words, like Samson without his hair or Peter following his infamous denial of Christ, the psalmist' cry is born out of an inexplicably deep sense of despair and frustration because he feels left out or cut off from divine relationship. He feels the full weight of the pain of aloneness, of forsakenness or abandonment. Further, the expression, "roaring words" is a direct translation of the Hebrew word "שְׁאָגָתִ," or

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[15] Peter C. Craigie and Marvin E. Tate, *Word Biblical Commentary*, vol. 2, *Psalms 1-50* (Rio De Janeiro, Brazil: Thomas Nelson Inc., 2004), 197.

[16] Strong, *Strong's Exhaustive Concordance*, 108.

"sheagah."[17] It connotes the roars of raging lions (as in Isaiah 5:29) or the desperate pleas of a human in overwhelming distress (as in Ps. 32:3). In these first two verses the psalmist presents to us the heart-wrenching circumstances of abandonment and the shocking reality that there is no help in sight, not even from God. Then when all seemed hopeless, in the words of the old gospel song, "something got a hold of him" in verses three through five causing him to summon deeper faith.

In verses three through five, the psalmist writes, "But thou art holy, O thou that inhabitest the praises of Israel. Our fathers trusted, and thou didst deliver them. They cried unto thee, and were delivered: they trusted in thee, and were not confounded." This appears to be a kind of crisis of conscious, when a person's belief clashes with what he or she is experiencing. Theologians Nancy Declaisse-Walford, Rolf A. Jacobson, and Beth Laneel Tanner concur with this notion when they write, "Crying out in pain and expressing trust are not incompatible. Faith and trust ebb and surge in life, and the appearance of contrasting situations causes a clash in the one suffering. I know what I feel and I know what I believe. The prayer clearly demonstrates the emotional roller coaster of the suffering of a faithful one."[18] In the midst of all his suffering, stewing in pain and adversity, the psalmist desperately attempts to hold on to his faith and trust in a God who has a long and established record of coming through for His People.

Then in almost dirge like fashion, the psalmist returns to a woeful lament. He likens himself to a "worm" all alone and rejected by people (v. 6). He says he is the subject of mocking, and perpetual harassment from scorners who seem to take delight in

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[17] Strong, *Strong's Exhaustive Concordance*, 111.

[18] Nancy Declaisse-Walford, Rolf A. Jacobson, and Beth Laneel Tanner, *The Book of Psalms* (Grand Rapids MI: William B. Eerdmans Publishing Company, 2014), 233.

his suffering. Next, in what seems to be messianic undertones the psalmist further offers insight into the psychological, emotional, spiritual, as well as, physical nature of his suffering. He writes:

> I was cast upon thee from the womb: thou art my God from my mother's womb. Be not far from; for trouble is near; for there is none to help. Many bulls have compassed me: strong bulls of Bashan have beset me round. They gaped upon me with their mouths, as a ravening and a roaring lion. I am poured out like water, and all my bones are out of joint: my heart is like wax; it is melted in the midst of my bowels. My strength is dried up like a potsherd: and my tongue cleaveth to my jaws; and thou hast brought me into the dust of death. For dogs have compassed me: the assembly of the wicked have enclosed me: they pierced my and hands and my feet. I tell my bones: they look and stare upon me. [18]They part my garments among them, and cast lots upon my vesture (Ps.22:10-17).

In verses nineteen through twenty-one, The Psalmist once more turns to his faith and trust in God and his lament becomes a prayer. Then in verse twenty-one, something very peculiar happens. It is as if the psalmist pauses mid-prayer and shouts, "You have answered," and from here forward the remaining psalm shifts from lament and prayer to praise and worship. Why? What happened? Well, the answer may be in the pause itself. The phrase, "you have answered," is best captured in the Hebrew language by the verb, "עָנִיתָנִי" or "ă·nî·ṯā·nî." It means to eye, to heed, to pay attention, to announce or to answer. The psalmist is declaring that the God who is the rock of ages, the God of his forefathers, of Abraham, Isaac, and Jacob heard his despairing cry and in seemingly instantaneous fashion answers him in real time. The psalm suddenly shifts from lament to celebration, to individual and corporate praise and worship. Theologians Peter C. Craigie and Marvin E. Tate in their commentary on this sudden shift or change in tone and mood of the psalm suggests that something extraordinary occurred at verse twenty-one that radically changed the remaining text and the ultimate outcome of the psalm from lament to celebration. They attribute the shift to a sudden answer to the prayer by an

oracle. They write "the words come in such striking contrast to the preceding lament and prayer that one must presuppose the declaration of an oracle announcing healing and health, after the prayer (v. 20-22b) [19-21b], which gives raise to this sudden declaration of confidence."[19]

Craigie and Tate believe that the psalmist's actual context was a public worship service for people who like the psalmist suffered from various afflictions and illnesses possibly unto death.[20] Tate also believes that the occasion was a special worship services for people such as these. He further believes that in the context of this liturgical experience, a priest or prophet brought the good news of deliverance to the worship leader which explains the sudden shift in tone from lament and prayer to thanksgiving and praise.

In verse twenty-three, the psalmist addresses the lord with thanksgiving and even mentions the assembly or congregation. He says, "Let me tell of your name…I will praise you in the midst of the congregation." In verses twenty-four through twenty-seven, he invites the whole assembly to join him and thanksgiving, and in verses twenty-eight through thirty-two this becomes full blown worship. However, the question to be answered is whether or not Psalm the twenty-second chapter can be said to be messianic? Is the psalmist prophetically pointing Mark 15:34 and Jesus' cry of dereliction? What does the Psalm say about the interpretation of Marks passion narrative? Is Jesus' recitation of the Psalm's opening verse a shout of victory in anticipation of the resurrection as indicated by the celebration at the latter part of Psalm the twenty-second

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[19] Craigie and Tate, *Word Biblical Commentary*, 198.

[20] Craigie and Tate, *Word Biblical Commentary*, 198.

chapter or an expression of lament attributed to abandonment communicated in the former? Historically, Christianity has taken the latter view and sees the cry as one lamenting the forsakenness that Jesus felt in isolation from God. Quoting a couple of prominent patristic fathers, Ambrose and Augustine, the *Ancient Christian Commentary* on scripture records the following:

> *His Recollection of Psalm 22. Ambrose*: As a human he doubts. He experiences amazement. It is not his divinity that doubts, but his human soul. He had no difficulty being amazed because he had taken upon himself a human soul. As God he was not distressed, but as human he was capable of being distressed. It was not as God that he died, but a man. It was in human voice that he cried: My God, My God, why have you forsaken me? As a human therefore, he speaks on the cross, bearing with him our terrors. For amid dangers it is a very human response to think ourself abandoned. As human, therefore, he is distressed, weeps, and is crucified. (On the Christian Faith 2.7.56)
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> *Appropriating the Psalmist's Voice to Himself. Augustine*: Out of the voice of the psalmist, which our Lord then transferred to himself, in the voice of this infirmity of ours, he spoke these words: "My God, my God, why have you forsaken me? He is doubtless forsaken in the sense that his plea was not directly granted. Jesus appropriated the psalmist's voice to himself, the voice of human weakness. The benefits of the old covenant had to be refused in order that we might learn to pray and hope for the new covenant. Among those goods of the old covenant which belong to the old Adam there is a special appetite for the prolonging of this temporal life. But this appetite itself is not interminable, for we all know that the day of death will come. Yet all of us, or nearly all, strive to postpone it, even those who believe that their life after death will be a happier one. Such force has the sweet partnership of flesh and soul. (Letter 140, To Honoratus 6).[21]

Similar arguments were raised in the third and fifth centuries by great thinkers like Irenaeus, Origen, Athanasis and the Cappadocian Fathers during the controversies and Doctrine of the Trinity. All attempting to bring clarity to exactly who was this God-Man who hung on the cross crying, "My God, my God, why hast thou forsaken me. However,

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[21] Thomas C. Oden and Christopher A. Hall, eds., *Ancient Commentary on Scripture: New Testament II, Mark* (Downers Grove, IL: Intervarsity Press, 1998), 222.

many contemporary thinkers take exception to the historical abandonment motif associated with Jesus' cry at the cross.

Theologian Gerardo Alfaro takes a critical look at the historical view of Jesus cry in Mark 15:34 in an article entitled "Review Essay: Did God Abandon Jesus at the Cross?" He bases his observations and arguments on a book by theologian Holly Carvey entitled, *Jesus' Cry from the Cross: Towards a First-Century Understanding of the Intertextual Relationship between Psalm 22 and the Narrative of Mark.*[22] Carey's basic criticism is that conservative interpreters have read Mark 15:34 from an "atomistic" perspective which may not be what the author intended or his "implied," readers would have understood. She contends that the true meaning of Jesus 'cry is found not just in reading the whole of Psalm the twenty second chapter, but also in looking at the literary patterns evident in Mark's Passion narrative and gospel. She argues that every prediction of Jesus' death in Mark's narrative is followed by an assurance of His resurrection (8:31, 9:30-31, 10:33-34). This follows the same pattern of the Psalm when read in its entirety; it moves from suffering to vindication. Alfaro suggests that trying the link Jesus's cry in Mark 15:34 solely to Psalms 22:2 is "bluntly simplistic." He further agrees with Carey that Mark's "implied" readers would have been familiar enough with his literary pattern and with Psalm the twenty second chapter as a whole to have immediately connected Mark 15:34 with vindication and victory. It is as if they were conditioned to expect victory and vindication at the time of His death which directly impacted their perception of the cry, "My God, my God, why has thou forsaken me?" Thus, Alfaro highlights

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[22] Gerardo A. Alfaro, "Review Essay: 'Did God Abandon Jesus at the Cross?'" *Southwestern Journal of Theology* 53, no. 2 (Spring 2011): 198-2007, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

liturgical tradition, familiarity, and the commonly held motif of vindication of a Righteous Suffer as three points of historical evidence of her thesis.[23]

For both Carey and Alfaro any attempts to interpret Jesus' cry apart from its larger context (the whole of Ps. 22), and Mark's literary pattern of death-resurrection-vindication are objectionable because they have led to faulty interpretations and teachings especially concerning the issue of abandonment. Alfaro writes, "reading Mark 15:34 in context should include being sensitive to the intricate layers of the narrative, and resistance to extracting the text from its surrounding context.[24]" He then discusses what he sees as four important questions Carey raises as guideposts to help more adequately interpret the cry. First, she questions the meaning of the word abandonment. She suggests that, "in the whole bible, with only one possible exception, God does not 'abandon' in the sense of removing His presence."[25] Thus for her, this makes the meaning in this text ambiguous. Second, she asks, "Is there any suggestion in the text that God did not abandon Jesus?[26]" She see the tearing of the temple curtain and the centurion's confession as indicative of the fact that God did not abandon Jesus in the sense of absence of divine presence. Third, "If God really abandoned Jesus at the cross, how do we explain his close and intimate relationship with Jesus throughout Mark's

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[23] Holly J. Carey, *Jesus' Cry from the Cross: Towards a First-Century Understanding of the Intertextual Relationship between Psalm 22 and the Narrative of Mark's Gospel* (New York, NY: T and T Clark, 2009), 109.

[24] Alfaro, "Review Essay," 199, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[25] Alfaro, "Review Essay," 199, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[26] Alfaro, "Review Essay," 199, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

narrative?"[27] For Carey, the nature of their relationship is one of the strongest proofs against abandonment. Carey's final guidepost addresses the concerns of those who have a problem with Jesus suffering while God is still present. Explaining this view Alfaro writes:

> To say that God did not abandon Jesus at the cross does not mean that Jesus' suffering was not real or severe. In other words, affirming that Jesus 'suffering is not due to God's personal absence does not take away its seriousness and importance for the argument of the Gospel. Jesus' suffering is as real as that of Palm 22. However, Mark does not want his readers to get the idea that "Jesus was completely and utterly abandoned by God without receiving His intervention as the psalmist had. If that were the case, why did he include such a triumphant ending of vindication is his narrative?"[28]

Like Carey, Alfaro believes that reading Mark 15:34 in context should include a sensitivity to the intricate layers of the narrative, and resistance to extracting the text from his surrounding context. As a theological implication he concludes by stating, "Oftentimes the interpretation of the cry of Jesus has come either from a systematic point of view or from a theodicy previously accepted. In order to correct this, the meaning of the cry of Jesus has to come first from the literary context where it is placed in Scripture. We need to be grateful for Holley Carey for doing just that."[29]

Alfaro also agrees with Carey's take on the how abandonment is defined. He writes, "If by "abandonment" you say that God did not do anything to stop the crucifixion, then I do not see how you can deny it. If by "abandonment" it is meant the God and Father (the triune God indeed!) wanted this to happen, then there is no way to

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[27] Carey, *Jesus' Cry from the Cross*, 163.

[28] Alfaro, "Review Essay," 199, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[29] Alfaro, "Review Essay," 201, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

oppose it from a biblical standpoint."[30] No, he did not disagree with this understanding of "abandonment." His disagreement was with those primarily conservative and historical theologians who claimed that God, out of "disgust," "frowned" on Jesus and "turned His back on Him." His primary contention is that apart from Mark and Matthew's statements about abandonment (the significance of which is refuted by Carey), there is simply no corroborating scriptural support that God "turned His back on Jesus.[31]" For Alfaro, any attempt to separate the sacred unity of the Father and Son is an exercise in futility. Famed theologian Karl Barth referred to this approach to abandonment as "the supreme blasphemy."[32] Further, quoting Barth Alfaro writes, "God gives Himself, but He does not give Himself away….He does not come into conflict with Himself. He does not sin when in unity with the man Jesus, He mingles with sinners and takes their place."[33] In light of this view, Alfaro goes on to make serval theological observations.

In addition to lack of direct scriptural evidence, Alfaro sees problems with some indirect scriptural support employed by conservative interpreters. One such passage is 2 Corinthian 5:21, "For he hath made him to be sin for us, who knew no sin; that we might be the righteousness of God in him." Alfaro argues that this passage suggests that sense God hates sin, and Jesus became sin for humanity, God had to separate from or reject him which explains the cry of dereliction. However, Alfaro contends that word for "sin" in

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[30] Alfaro, "Review Essay," 201, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[31] Alfaro, "Review Essay," 201, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[32] Alfaro, "Review Essay," 201, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[33] Alfaro, "Review Essay," 201, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

this passage could actually be interpreted "offering for sin."[34] He argues that this presents the Father in a different light, not absent, but as the one making the sacrifice and therefore, present at the cross. Further, Alfaro questions that even if one wanted to interpret the word as "sin," are we really trying to say that Jesus really became sin?[35] For if God hates sin, how could Jesus, as sin, be an acceptable offering? Finally, Alfaro asserts about this passage that it, like no other, places God at, not absent from, the cross. 2 Cor. says that "…God was in Christ reconciling the world unto himself."

Another theological observation made by Alfaro asks, "Whether Jesus was ignorant about the reasons of God's actions at the cross?[36] Alfaro asserts that the idea of Jesus questioning God's presence at the cross could be problematic for conservatives. If Jesus' cry can be taken literally, are we really willing to say that Jesus did not know why God abandoned him? Throughout the gospel narratives, Jesus is presented as fully aware and accepting of his earthly mission. If this is so, then for Alfaro, conservatives would have to admit that his question does not make sense. Should the question even be taken literally? If so, Alfaro argues, we need to acknowledge it for what it is, a question about abandonment, not an affirmation thereof. Other theological observations made by Alfaro regarding abandonment or divine separation involves its impact on our understanding of the Holy Trinity and the role of the Holy Spirit at thec. Essentially Alfaro concludes, "Punishment of sin in the Son takes place in that God does not intervene to stop the

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[34] Alfaro, "Review Essay," 202, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[35] Alfaro, "Review Essay," 202, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[36] Alfaro, "Review Essay," 203, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

crucifixion. But this does not mean He abandoned the Son in the sense of taking His presence from him."[37]

However, theologian Matthew S. Rindge in his work, "Reconfiguring the Akedah and Recasting God: Lament and Divine Abandonment in Mark," refutes arguments like those presented by Carey and Alfaro.[38] He takes exception to the approach of using the whole of Psalm the twenty second chapter to interpret Mark 15:34 as a means of pointing beyond lament and abandonment to focus on vindication and praise. He writes, "many interpreters see Mark's Jesus as a righteous or innocent suffer and read the citation of the psalm as a reference to subsequent divine vindication."[39] Rindge believes that it remains uncertain as to whether Jesus's cry is actually invoking the entire psalm and if doing so even substantiates the emphasis on praise and vindication. For Rindge such approaches can have diminishing effects on the biblical narrative. He holds that "neglecting or minimizing Mark 15:34 contributes to incomplete and inaccurate understandings of Markan theology."[40] Rindge's refutation of Carey and Alfaro theories rests on three important points. First, based on the works of Claus Westermann,[41] Tony W.

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[37] Alfaro, "Review Essay," 206, accessed February 16, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org/.

[38] Matthew S. Rindge, "Reconfiguring the Akedah and Recasting God: Lament and Divine Abandonment in Mark," *Journal of Biblical Literature* 131, no. 1 (April 2012): 755, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[39] Rindge, "Reconfiguring the Akedah and Recasting God," 758, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[40] Rindge, "Reconfiguring the Akedah and Recasting God," 756, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[41] Claus Wetermann, *Praise and Lament in the Psalms,* trans. Richard Neuvins and Keith R. Crim (Louisville, KY: John Knox, 1981), 75-78.

Cartledge,[42] and Stephen Adhearn-Knoll,[43] Rindge offers another interpretation of the shift from lament and prayer to praise and worship at Psalm 22:21. Accordingly, the shift is not due to the sudden input of an oracle as previously suggested, but to a shift in mindset or strategy on the part of the author. He suggests that it is not "actual praise" being offered, but "promised praise."[44] This is evidenced Rindge asserts, in agreement with the above- mentioned theorists, by the use of future-tense verbs in the psalm's praise section. In the coupling of the psalm's opening lament with an ending promise of praise in exchange for deliverance and vindication, Rindge sees a kind of bargaining with God. This he believes nullifies the argument of an eschatological vindication of the "righteous suffer.[45] This, by the way, seems consistent with some of David's other psalms of vindication and vengeance (17, 35, 54, 107 etc.); a promised devotion or service in exchange for deliverance. It is even supported by other Old Testament narratives like Abraham negotiating with God on behalf of Sodom and Gomorrah (Gen. 19). Using Alfaro's historical-cultural argument, there's no reason to believe that the Psalmist lacked familiarity of that biblical tradition as well (that of having a God one could reason with).

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[42] Tony W. Cartledge, "The Listening Heart: Essays in Wisdom and the Psalms in Honor of Roland E. Murphy," *Journal for the Study of the Old Testament Pr.* (1987): 77-94, accessed April 10, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[43] Stephen Adhearne-Knoll, *Challenging the Divine: LXX Psalm 21 in the Passion Narrative of the Gospel of Mark* (Leuven, Netherlands: Peeters, 2006), 119-148, ATLA0001709622.

[44] Rindge, "Reconfiguring the Akedah and Recasting God," 759, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[45] Rindge, "Reconfiguring the Akedah and Recasting God," 759, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

Second, based on the work of Vernon K Robbins,[46] Rindge argues that, "the order of the citations of – and allusions to- Psalm 22 in Mark 15 hints at a greater interest in abandonment than in vindication."[47] The order of Mark chapter fifteen and Psalm chapter twenty two parallels are as follows:

1. Mk 15:24 – "And when they crucified him, they parted his garments, casting lots upon them, what every man should take. Ps. 22:18 – "They part my garments among them, and cast lots upon my vesture."

2. Mark 15:29-31 – "And they that passed by railed on him, wagging their heads and saying, Ah, thou that destroyest the temple and buildest it in three days. Save thyself and come down from the cross. Likewise also the chief priests mocking said among themselves with the scribes, He saved others, himself he cannot save."

3. Psalm 22:7-8, "All they that see me laugh me to scorn: they shoot out the lip, they shake the head saying, He trusted on the Lord that he would deliver him: let him deliver him seeing he delight in him."

4. MK. 15:32 – "Let Christ the King of Israel descend now from the cross that we may see and believe. And they that were crucified with him."
   Ps. 22:6 – "But I am a worm, and no man, a reproach among men, and despised of the people."

5. Mk. 15:34 – "And at the ninth hour Jesus cried out in a loud voice, saying, Eloi, Eloi, lama sabachthani? which is, being interpreted, My God, my God why hast thou forsaken me?
   Ps. 22:1 - My God, my God, why hast thou forsaken me? why art thou so far from me, and from the words of my roaring?

Rindge observes that, "Robbins has shown that these scriptures are in reverse order, producing in Mark's passion narrative a 'backwards reading of Psalm 22."[48]

Subsequently, Robbins and Rindge are convinced Mark's reversal of sequence in his

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[46] Vernon K. Robbins, "The Reversed Contextualization of Psalms 22 in the Markan Cruxifixion: A Socio-Rhetorical Analysis," *Four Gospels*, no. 1 (1992): 179.

[47] Rindge, "Reconfiguring the Akedah and Recasting God," 759, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[48] Rindge, "Reconfiguring the Akedah and Recasting God," 759, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

usage of the psalm, changes the emphasis from praise to lament. Adding to Robbin's conclusion, theologian William Sanger Campbell notes that Psalm chapter twenty two, "as employed in Mark, descends toward defeat and abandonment, instead of ascending toward deliverance and thanksgiving, a decline capped by Jesus' outcry in 15:34. Rindge concludes, "Every citation of Psalm 22 in Mark 15 draws attention not to praise or vindication but rather to the suffering of the psalmist."[49]

Moreover, Rindge offers a literary critique of Carey's work. He concurs with Carey's argument that it is common in the Hebrew Bible and in rabbinic text to refer to an entire psalm or prayer by citing its incipit. However, this is not always the case. Referencing the work of Robert H Gundry,[50] Rindge points out that "many citations of the HB/LXX in the Gospels are of a line from the middle of a periscope."[51] In fact, Jesus' last words in Luke are not from the first verse but the fifth. To understand this critique requires understanding a couple literary terms, metalepsis and peshat. Metalepsis is derived from the Greek word metonymia. It means "substitution" or "sharing." It is an advanced form of figure-of-speech in which one thing refers to another thing that is only slightly related to it. It is often linked by either the proof of causal relations to seemingly unrelated things or through indirect intermediate replacement of terms.[52] Peshat is a term employed in Jewish Hermeneutics for, "the simple, obvious literal meaning of a biblical

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[49] Rindge, "Reconfiguring the Akedah and Recasting God," 760, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[50] Robert H. Gundry, *Mark: A Commentary on His Apology for the Cross* (Grand Rapids, MI: Eerdmans, 1993), 966.

[51] Rindge, "Reconfiguring the Akedah and Recasting God," 760, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[52] Literary Devices, "Definitions and Examples of Literary Terms," accessed May 9, 2018, https://literarydevices.net/.

text."[53] Rindge argues, some of Mark's citations of the Jewish scripture are examples metalepsis (e.g. Isa. 56:7b and Jer. 7:11 in Mk 11:7), but the broader literary context of these inter-texts usually comports with the peshat meaning of the text. It seems unlikely that Mark would cite a line that expresses the precise antithesis of the specific citation. Rindge further draws support from Hebrew Bible scholars who tend to suggest that both Jesus' prayer in the garden (Mk 14:34-36), and the cry from the cross contain standard components of a lament psalm: an expression of human suffering, an appeal to God to remove the suffering, expression of volatile emotions directly to God, a complaint to God about God; and a question about the perceived distance of God. In fact, many Hebrew scholars who comment on the cry of dereliction see in it an emphasis on lament rather than praise and vindication. Interestingly, these are the people believed to be more culturally connected to Carey's "implied audience," yet they embrace an all-together different view of Mark 15:34 than the one she presumed.

Rindge concludes by focusing on the humanity on display in Jesus between the Garden and the cross. In the garden we witness a sudden, unexpected, and inexplicable mood change in Jesus. One which seemingly transforms our courageous King from a bold, confident and willing Messiah, to an uncertain, possibly dreadful human being. Jesus specifically asked God to remove suffering from him. Rindge also notes that in addition to the verbal petitioning, Jesus' emotions drastically intensify. Jesus began to buckle under the weight of distress and anguish; literally confessing, "my soul is exceeding sorrowful unto death, (Mk 14:34)." He then cried out is desperation to his Father for deliverance. Rindge then references theologian Raymond Brown's

[53] Encyclopedia Britannica, "Peshat," accessed May 9, 2018, https://www.britannica.com/.

observation that is in both prayers, the garden and the cross, Jesus speaks Aramaic and addresses the deity as "God" rather than "Abba" or "Father."[54] Further, Patrick D. Miller observes the repetition in Mark 15:34 of "My God, my God" is unusual in the laments, [and] a clue to the intensity of the cry.[55] This cry resonates with Mark's audience, themselves acquainted suffering Miller writes:

> Mark's audience "hears not simply moans but the desperate, even angry, outcry of the suffer. The "roaring" in the psalm draws attention to the intensity of the psalmist's complaint, one that is also reflected in Mark's description of Jesus' suffering. Related to this intensity – and the question that opens the psalm- is the accusation that God is to blame for the psalmist's suffering. Jesus cry in 15:34 reinforces a central component of lament psalms, namely, the complaint that God is the direct cause of the suffering of the one who laments.[56]

Rindge believes like many other conservative interpreters that Jesus cry on the cross is in fact, a lament, springing forth of unimaginable grief primarily from his human nature as he wrestles with the imminent reality of death and dying from the garden to the cross. This understanding stands deeply entrenched in Christianity from the struggles of early church fathers like Irenaues, Origen, Athanasius, and the Cappadocians in the doctrinal debates over the Trinity and Christology among others during the third, fourth and fifth centuries.[57] As it turns out Jesus is both fully man and fully God, "consubstantial." This author believes that in the laments from both the garden and the cross the reader witnesses the human side of Jesus wrestling with the imminence of his own demise, the

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[54] Raymond E. Brown, *Death of the Messiah: From Gethsemane to the Grave, A Commentary on the Passion Narratives in the Four Gospels*, vol. 2 (New York, NY: Doubleday, 1994), 1046.

[55] Patrick D. Miller, *Interpreting the Psalms* (Philadelphia, PA: Westminster Press, 1986), 101.

[56] Rindge, "Reconfiguring the Akedah and Recasting God," 771, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[57] Edward Rochie Hardy and Cyril R. Richardson, eds., *Christology of the Later Fathers, Library of Christian Classics* (Philadelphia, PA: Westminster Press, 1954).

way humans do, with travail. He's not alone in this. No, Rindge suggests that the pain of forsakenness in Jesus' cry is what really resonated with Mark's audience.[58] It did so because they themselves from the depths of their own socio-political and historical narrative, individually and collectively identified with the disappointment, heartache, angst and pain of suffering. Of the psalmist's lament and prayer, Tanner writes:

> One wonders why the one praying feels so ashamed and mocked (v.7). But the truth be told, one does not have to look far to understand. President Roosevelt hid his polio because he knew people would equate paralysis for weakness. AIDS patients suffer from terrible shame as they must face not only their disease, but the questions of how they got it. Many suffer the depression and hurt that comes from not being "normal" in a culture where health and vitality are prized. The problem of course does not have to be sickness. Those who have been imprisoned or suffer from addictions or mental illness find the doors closed to full participation in society. Indeed, even the loss of a marriage or a relationship leaves one feeling as if he or she has failed and is looked down on by the world.[59]

She goes on to list biblical examples of Job's friend or Lepers or even Jesus himself, people who for various reasons, find themselves at the mercy of the anesthetized others, who instead of human kindness, empathy, compassion, and encouragement, can offer nothing more than scorn, judgement, ridicule and rejection. I am convinced that this is exactly the point of divine narrative. This is where God wants humanity; at the place of human frailty and failure, the revealing and vulnerable exposure of the human condition, at the cross. It would be a contradiction of God's ultimate purposes for this to be seen as a time of celebration although, a celebration is forthcoming. After Maundy Thursday, and Passion Friday, there is Celebration Sunday, but that time is not now; not in the six hours of suffering, not during the mocking, and harassment, not during the three hours of

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[58] Rindge, "Reconfiguring the Akedah and Recasting God," 772, accessed March 5, 2018, https://web-b-ebscohost-com.utsdayton.idm.oclc.org.

[59] Declaisse-Walford, Jacobson, and Tanner, *The Book of Psalms*, 234.

miraculous darkness. No, here something more somber, more sublime, more noteworthy is happening. The finite clashes with the infinite, the mortal with the immortal, in an epic showdown of cosmic proportion. It is what the Apostle Paul would later refer to as a continuous battle, "...against principalities, against powers, against the rulers of darkness of this world, [and] against spiritual wickedness in high places (Eph. 6:12)." On the Ccoss, we have a thirty-year-year old Jesus, the consubstantial "Son-of- God," and even more astonishingly, the "son-of-Mary" caught up in the middle it in an unimaginably horrific scene.

In his sermon "Sinners in the Hand of an Angry God," Johnathon Edwards once likened a Jesus on the cross to a spider hanging from its web over the fires of hell. After nine hours of suffering Jesus releases two final "roaring cries" that do not just resonate with Mark's audience, but with earthy audiences across the spectrum of time. His cry changed the world of human history. In it is the hope for all suffering souls. Jesus literally models for a broken and wounded humanity what to do with their suffering, bring them wounded, battered, and even bleeding to the cross and cry out with everything in you for deliverance. The good news is that the awful and horrendous price for humanity's health, healing and happiness has already been paid! Carey and others are not wrong in wanting to rush pass lament to get to vindication and celebration. The harsh realities of pain and suffering are difficult for anyone to deal with. But in haste to get to vindication and celebration, we make the vital error of missing the quintessential message of the suffering Savior: honesty, grace, compassion, forgiveness, reconciliation, and ultimate victory. That is what believers identify with and that's where our help comes from. The task is to find creative ways of translating and communicating this message in

and outside the religious context because the messages of the Cross still has relevance in a world still struggling with death and dying.

CHAPTER THREE

HISTORICAL FOUNDATIONS

They were considered modern and post-modern miracles. On September 12, 1895 a thirty-seven-year old French Nun, Simplicia Hue of the Sisters of the Sacred Heart contracted an intestinal illness and was reportedly near death. She prayed for intercession to a famed Roman Catholic Priest, Fr. Damien de Veuster who died six years prior in 1889 on the Hawaiian Island of Molokai. She was miraculously healed overnight and went on to live another thirty-two-years. Then in 2000, a seventy-nine-year old retired Hawaiian High School teacher, Audrey Toguchi, "experienced a completely spontaneous regression" of advanced stage lung cancer after praying to Fr. Damien and making a few pilgrimages to the island of Kalaupapa where the revered Priest served and sacrificed his life.

Toguchi is the granddaughter of a Hansen's disease (leprosy) patient, the much-ostracized population for whom Fr. Damien lived and died. On June 13, 1992 the first miracle was approved by the Vatican and Fr. Damien was beatified by Pope John Paul II on May 15, 1995. Then on July 3, 2008, the Holy Father signed a decree confirming the healing of Toguchi a miracle, and on October 11, 2009, Pope Benedictus XVI officially canonized the priest St. Damien de Veuster of Molokai. Even the then sitting President of the United States, Barack Obama, also of Hawaiian background, expressed admiration for Fr. Damien. In an interview with CBS News on October 9, 2009, he reflected on

childhood stories about the priest's service to those suffering from leprosy and stigmatization. He called on the world to follow Damien's example by, "answering the urgent call to care for the sick." Exactly who was Fr. Damien de Veuster and what made his contribution to humanity so worthy of praise and veneration?

Fr. Damien was a nineteenth century Belgium born Roman Catholic Priest who served as a missionary to the Hawaiian Islands. He came to fame for the selfless service and compassionate care with which he ministered to the needs of leprosy victims on the Island of Molokai. He spent the final sixteen years of his life tending, not only to the spiritual needs of these suffering out-casts, but also to their medical, social, educational, and practical needs as well. He was also reputed to have been a bit brash and confrontational towards governmental authorities concerning their negligent and discriminatory practices and their failure to adequately support the banished lepers at Molokai. Fr. Damien is said to have so identified with his new community that he often addressed them as "we lepers."[1] He eventually contracted leprosy himself and died at the young of forty-nine. The news of Fr. Damien's story and untimely death made him an international icon of human compassion and decency. It also elevated the global conversation about leprosy and the treatment of its victims. Therefore, the purpose of this chapter is to glean from Fr. Damien's experiences with compassionate care, lessons to help us better understand the needs of society's terminally ill and their caregivers. This will be accomplished by first reviewing Damien's life journey which led him to the mission field. Next, the chapter looks at the mission itself and more closely examine Hawaii's leprosy crisis in the mid-nineteenth century which resulted in the infamous

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[1] John Farrow, *Damien the Leper: A life of Magnificent Courage, Devotion and Spirit* (New York, NY: Double Day Dell, Inc., 1954), 188.

Molokai experience. Third, I'll explore Fr. Damien's work, supports, and possible sources of inspiration. The chapter concludes by examining the insights that Damien's Molokai experience offer today's practitioner of compassionate care to the terminally ill and their care givers.

Born on January 3, 1840 in Tremeloo, Belgium to Francois and Catherine de Veuster. Damien was their sixth child. They were a very devout Roman Catholic family. Damien's birth name was given to him by his godfather who wanted to name him after the "Head of the Holy Family" so he named him Joseph de Veuster. John Farrow in his book, *Damien the Leper* described Tremeloo as a small peaceful agricultural community in which farming was a generational trade.[2] Men inherited land from their fathers and were expected to farm it until they passed it on to the next generation.

Francois de Veuster was a fairly successful farmer who dutifully sought to pass the family business on to his children. Farrow points out that daily he would take the three older children with him to work the fields and to learn the family business while the three younger ones, Auguste, Pauline, and Joseph, stayed home with their mother. Joseph's first exposure to formal education would be during those cherished days at home with his mother who constantly read books to them from the family's library. Most of the materials they learned dealt with church or religious history. Mrs. de Veuster's lessons filled her three younger children's imaginations and spurred their interests and passions for the "religious life." She would pour over volumes of books filled with stories about the lives and struggles of the church and its Saints. Joseph and his siblings

[2] Farrow, *Damien the Leper*, 1-14.

were captivated by the lives of saints and missionaries who faced and endured many dangers and threats in the name of God and compassionate care.[3]

One such story involved the third century Patron Saints of Medicine, the Arabian twins Damian, a pharmacist and his brother Cosmos, a physician. Their legend involves many stories of miraculous healings and deliverances as they sought to administer God's grace and compassion to the disenfranchised and suffering free of charge. This offended the authorities who considered their growing fame a threat to their hegemony and unsuccessfully sought to subjugate them. The brothers were both eventually martyrized by beheading as a result of their ministerial expediency.[4] Young Joseph was so impressed with Damian's story, that it would later inspire his own sense of calling and ministry. In fact, all three of the younger de Veuster children ended up serving in ministry. Even as a youth, Joseph harbored a heart of self-sacrificing compassion. Farrow tells the story of how he once encountered a hungry man and stole a whole ham from his mother's kitchen to feed the man leaving his whole family without supper that day. Needless to say, his father was none-too-pleased about this. In addition to caring for others, Joseph also became quiet proficient at manual labor and skilled at working with his hands. These skills would serve him well later in life.[5]

Tremeloo during this period was a patriarchal society. Thus, fathers held the sole privilege and responsibility of dictating their children's career paths. Francois de Veuster was no exception. He decided that the three older de Veuster children would

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[3] Farrow, *Damien the Leper,* 15-41.

[4] "Golden Legends – Lives of Saints Cosmos and Damien," Catholic Saints Info: Notes About Your Extended Family in Heaven, accessed August 1, 2018, http%3A%2F%2Fcatholicsaints.info.

[5] Farrow, *Damien the Leper,* 15-41.

inherit and operate the family farm. Further, being a devout Catholic, he held no objections when both Auguste and Josephine expressed interest in religious occupations. However, when it came to his youngest son Joseph, he had different plans. He wanted Joseph to become a merchant, a businessman. Under the leadership of King Leopold I, Belgium's economy was bustling at the time, especially in the area of international trade. Like many parents, the de Veusters dreamed that a career in commerce would prove prosperous for their youngest son, and through him, the family. Joseph's parents sacrificially scraped up whatever funding they could to send Joseph off to college. He studied at the Brain-le-Compt Academy in the Province of Hainault, Belgium.[6]

Although Joseph was doing well at the school, he nonetheless felt a deep sense of ambivalence. Like his siblings, he never outgrew his passion and sense of calling to the "Religious Life."[7] To his parent's disappointment, he subsequently followed his older brother Aguste (Fr. Pamphile) into the priesthood. In 1859, he was accepted into the novitiate of the Congregation of the Sacred Hearts of Jesus and Mary. Upon entering training, priest candidates of the time were to adopt new names. Interestingly, Joseph chose the name Damien, after the then canonized third century healer. In 1863 Damien and his brother Fr. Pamphile (Auguste) petitioned their superiors for a long-term missionary assignment to the Hawaiian Islands. Fr. Pamphile was accepted in that he was already an ordained Priest, but Damien, still a student, was not. However, Fr. Pamphile's duties led to his administering the Last Sacraments during a typhus epidemic and contracting the disease himself. He was unable to take on his missionary assignment.

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[6] Farrow, *Damien the Leper,* 24.

[7] Farrow, *Damien the Leper,* 25.

Damien, not yet ordained, in a bold and brazen move surpassed his direct report and sent a written request to take his brother's place to the order's Superior General. Surprisingly, the request was granted, and Brother Damien arrived in Honolulu on March 19, 1864. He was ordained a priest two months later on May 21, 1864. He was twenty-four-years old. Although very excited about his new mission, Damien knew that accepting it meant that he would never again see his family or return to his homeland in Louvain.[8] After serving a nine- year tenure at his first pastorate at a parish on the island of Puno, Hawaii, Damien's faith once more inspired him towards a higher sense of purpose.

In 1873, Hawaii's Board of Health passed a new law which prohibited any priest assigned to the leper colony at Molokai on the Island of Kalaupapa from ever leaving. They would, like the lepers themselves, be considered banished to live and die on the Island. It was in fact, a life-time appointment. Prior to this new law priestly appointments there occurred by rotation. Damien was one of only four to initially volunteer. He was selected because he was more experienced and because of the reputation of his good works at Puno.[9] Once more Fr. Damien conscientiously and courageously agreed to surrender his life in offering compassionate care and service to society's disenfranchised and terminally ill. Due to the inhumane practices of compulsory segregation, governmental neglect, poor housing, insufficient food supplies, inadequate medical care, and a severely progressive terminal illness, Kalaupapa was considered a "hell on earth;" an island so deplorable that it was surnamed: the "natural

[8] Farrow, *Damien the Leper,* 28-40.

[9] Farrow, *Damien the Leper,* 102.

prison," or "the grave where one is buried alive."[10] It was to combating leprosy and serving these unfortunate souls that Fr. Damien would commit the rest of his life. Even more deplorable is the way that Europeans colonizers used the leprosy as a kind of manufactured crisis to seize dominance over Hawaii and her people.

To be sure, leprosy did not originate among the Polynesian people of Hawaii, nor can it be said to be a race-based illness as some have historically claimed. In fact, many foreign diseases and epidemics were introduced to the natives of Hawaii by the crew of the legendary Sea Explorer, Captain James Cook in 1778.[11] These included: syphilis, gonorrhea, tuberculosis, influenza, diphtheria, measles, smallpox, whooping cough, and many others. None were more stigmatizing, demoralizing, or dehumanizing as Hansen's disease or leprosy. Not because it was more threating than the other diseases, but because of the historical, social, economic and racial nuances affixed to it. The truth of the matter is that leprosy, at least some version of it, is one of the world's oldest diseases dating all the way back to the early biblical era. In his description of leprosy Farrow observes:

> Death before death is what the ancient Egyptians called leprosy. It is a fit description. Down through the centuries it has been called the most incurable, the most dreaded of diseases. The Hebrews scribes wrote of its horror. Roman and Greek writings show that those races shared the same fear. Today, still baffling the ingenuities of modern science, it remains a scourge to mankind.[12]

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[10] Kerri A. Inglis, "One's Molokai Can Be Anywhere: Global Influence in the Twentieth Century History of Hansen's Disease," *Journal of World History* 25, no. 4 (2014): 611-627, accessed July 16, 2018, https://www.jstor.org/stable/43818467.

[11] Inglis, "One's Molokai Can Be Anywhere," 613-614, accessed July 16, 2018, https://www.jstor.org/stable/43818467.

[12] Farrow, *Damien the Leper,* 107.

Further, Kerri A. Inglis in her article, "One's Molokai Can Be Anywhere: Global Influence in the Twentieth Century History of Hansen's Disease," traces leprosy to India in 600 B.C. or to China and the Nile valley during earlier periods. By 62 B.C it reached the Mediterranean and further Northward with Pompey's the northern expansion.[13] By the twelfth and thirteenth century nearly a quarter of Europe's entire population were lepers. None more "sorely affected than England.[14] This was attributed to poor personal and public cleanliness, sanitation, and diet. Borrowing from biblical history and Levitical law, the historical response to leprosy was isolation and separation, if not criminalization of its victims. It was known as the "Death before Death" throughout the ancient world because of the horribly inhumane treatment of those so afflicted. Compulsory segregation is believed to be steeply rooted in religious traditions. According to Levitical law, "And the leper in whom the plague is, his clothes shall be rent, and the hair his head shall grow loose, and he shall cover his upper lip, and shall cry unclean, unclean. All the days wherein the plague is in him shall be unclean; he is unclean; he shall dwell alone; without the camp shall his dwelling be" (Lev. 13:45).

Moreover, in medieval England decrees were issued to further stigmatize or harass lepers and strongly limit their social contact. Farrow quotes one such decree in detail:

> The leper must not go about without his black cowl. He must not enter churches, mills or bakeries. He must not come to fairs or markets. He must not wash face or hands in public drinking fountains. He must not touch anything except with his stick. He must no speak unless spoken to or until he who speaks is to windward of him. He must not walk along narrow ways at the evening-tide. He must not

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[13] Inglis, "One's Molokai Can Be Anywhere," 612, accessed July 16, 2018, https://www.jstor.org/stable/43818467.

[14] Farrow, *Damien the Leper,* 110.

> live in town or village. His only dwelling must be in the open country far from men and the roads.[15]

What made this stigmatization more heinous was the over-abundance of misdiagnoses by ill-informed and inadequately trained medical expertise at the time. Once diagnosed "lepers" were immediately subjected to public humiliation and ostracism. The pronouncement was posted publicly, and lepers were turned over to ecclesiastical authorities for final blessings and burial rites. They would be sprinkled with water, prayed over, and led in procession by cross bearer and priest to the church. There they would be forced to undergo a formal funeral mass. Their family and friends would be present dressed in funeral attire and grieving him as "irretrievably lost to this world.[16] In lieu of a coffin, the leper would have to kneel beneath a canopy of black cloth. Afterwards the leper would be led once more in procession draped in a black cowl to the cemetery where they would have to kneel as the clergy poured a handful of dirt on him as if he were a corpse symbolizing burial. Afterwards the leper, for all intents and purposes, was considered dead to this world. He would then be driven outside of town and forced to comply with the above stated decrees. People went to great lengths to avoid or altogether abandon lepers, even to the point of throwing bricks at them to chase them away. Interestingly it was also the church and so called "Lazar Houses, (discussed below," and the Black Plague that finally help quash the leprosy epidemic in Europe. In some respect it was fear of this horrible and dark period of European history that many

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[15] Farrow, *Damien the Leper,* 111.

[16] Farrow, *Damien the Leper,* 112.

westerners had either lived or heard about that affected their worldview as they entered the colonial era.[17]

However, when Cook and his crew arrived in Hawaii on his third voyage, he found it a land filled with pleasant, hospitable, and trusting people. In 1778, the population size of Hawaii was about 250,000 (some estimate as many as 400,000) people. As a consequence of colonialization, it was reduced to 53,000 by 1876, the time of Fr. Damien, and to 40,000 by 1890.[18] The prevailing question is exactly what caused a 79% decrease in the indigenous population of Hawaiians in less than a century when natural order and progression would suggest that the colonialization should have increased Hawaii's population size. In his book, *Leprosy, Racism, and Public Health,* author Zachary Gussow offers an explanation. He writes:

> Among leading causes of decrease in population were a decline in fertility and an increase in infant mortality produced by 1) diseases introduced by Western visitors, especially syphilis and gonorrhea, and 2) the disruption of the ancient social system and the "the discarding of the old kaput (taboos) that controlled kinship and dietary patterns [reducing] protective measures and [increasing] the susceptibility of Hawaiian infants to disease.[19]

Gussow also suggests that islanders lacked the "natural immunity or medical knowledge" to effectively deal with the influx of western disease such as: influenza, mumps, smallpox, whooping cough, scarlet fever, and tuberculosis.[20] In fact, an epidemic believed to be cholera accounted for between 5,000 to 15,000 deaths in 1804-1805 alone. Interestingly, by mid-nineteenth century, leprosy, although, less dangerous, became

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[17] Farrow, *Damien the Leper,* 111-115.

[18] Farrow, *Damien the Leper,* 91.

[19] Zachary Gussow, *Leprosy, Racism, and Public Health: Social Policy in Chronic Disease Control* (Boulder, CO: Westview Press, 1989), 87.

[20] Gussow, *Leprosy, Racism, and Public Health,* 87.

Hawaii's most infamous disease. Fearing the possible spread of leprosy back to Europe, supplanted Protestant missionaries and businessmen erringly blamed the Hawaiian people, their culture and lifestyle for the reemergence of leprosy and adopted the old models of strict isolation to suppress it. However, many scholars believe that this was a mere smoke screen concealing their ultimate motives of economic, political, and social dominance of the Kingdom of Hawaii. In other words, leprosy became a tool conflated with greed to justify the social and political oppression of the indigenous people.[21]

Pennie Moblo in her article, "Blessed Damien of Molokai: The Critical Analysis of Contemporary Myth" takes a closer look at economic and political dynamics that greatly impacted the leprosy crisis.[22] She argues that the Reform Party, made up of white missionaries, businessmen, and second generation Hawaiian born Americans, whose sole objective was economic prosperity and political dominance employed the concepts of myth and ideology to justify their politics. By "myth" she means, "a tale which is told to justify some aspect of social order or of human experience – a sacred tale that is divinely true for those who believe, but fairy tale for those who do not."[23] She borrows her definition of ideology from sociologist John B. Thompson for whom, "an ideology is a concept that calls our attention to the ways in which meaning is mobilized in the service of dominant individuals and groups...to establish and sustain structured social relations

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[21] Gussow, *Leprosy, Racism, and Public Health,* 90.

[22] Pennie Moblo, "Blessed Damien of Molokai: The Critical Analysis of Contemporary Myth," Ethnohistory 44, no. 4 (Fall 1997): 691-720, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

[23] Moblo, "Blessed Damien of Molokai," 696, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

from which some individuals and groups benefit more than others."[24] Mobile argues that, "while the details of myth (social form telling) change over time, the ideology (message) remains the remarkably constant: in the case of leprosy in Hawaii, the ideology legitimizes the relationship of domination by a foreign culture over natives."[25] Essentially, Mobile posits that leprosy was neither as wide spread nor as contagious as the government claimed. She quoted statistics from a 1915 Hawaii Bureau of Vital Statistics report which lists leprosy as ninth on a list of eleven diseases as cause of death for that year. Among natives, leprosy accounted for thirty-three out of 888 deaths that year, and thirty-nine out of 3,556 deaths for the general population. The top five deadliest diseases that year were Tuberculosis (349), Pneumonia (415), Nephritis (144), Heart Disease (120) Gastroenteritis (205) and cancer (128).[26] All of these killed more natives that year than did leprosy, but no such segregation laws were established to address or criminalize these. Nonetheless, in 1869 the foreigners pressured King Kamehameha I to sign the isolation of lepers to the Island of Molokai into law (though not strictly enforced until much later) Why? In a nutshell three words, greed, power, colonialization.

Captain Cook's discovery of the Hawaiian Islands in the late 1800s happened at a time during which dominance in maritime trade was shifting from Spain to Great Britain

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[24] John B. Thompson, *Ideology and Modern Culture* (Stanford, CA: Stanford University Press, 1990), 73.

[25] Moblo, "Blessed Damien of Molokai," 697, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

[26] Moblo, "Blessed Damien of Molokai," 697, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

and America.[27] As a result of the split between these two nations via the War of Independence, America turned her attention to trade with the East. Hawaii then was an ideal port between USA and China. Thus, Hawaii's natural resources (e.g. sandalwood, whaling and sugar) were brought to the trade table producing great wealth especially for white missionaries, businessmen, and Hawaiian elites (monarchs and chiefs). The sandalwood industry was so successful that by 1812, nearly four million pounds of the wood were shipped to China that year alone. However, commercialism also introduced devastating diseases and economic hardships to the Hawaii's economy and her people. With the emergence of a very prosperous sandalwood trade business, natural forests were being depleted. Farms and food supplies suffered because of the neglect invited by the booming wood and whaling industries. Unfortunately, the mass accumulation of wealth primarily benefitted the foreigners and local elites to the depravation of the populace. In fact, by his death King Kamehameha I acquired but had not paid for six large sailing vessels. The monarchy was literally in debt the Europeans to the tune of about $300,000 by 1824. Gussow argues that as a result of practices like these, "by the middle of the nineteenth century, Hawaiian monarchs, though retaining their throne and titles, nevertheless exercised less and less power in their own country."[28] They were literally reduced to vassal or puppet kings. Their status only worsened over the following few decades as Hawaii's evolving agricultural business and whaling became the center pieces of its economy with regards to international trade and European exploitation.

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[27] Gussow, *Leprosy, Racism, and Public Health,* 86.

[28] Gussow, *Leprosy, Racism, and Public Health,* 87.

American missionaries initially started coming to the islands in 1820. They were led by two ministers trained at Andover-Newton Theological Seminary in Boston. The group also contained one physician, one printer, one famer and two teachers. Gussow writes," at first, members were in a strict sense, "amici curiae," remaining in the background, teaching, and offering general counsel to Hawaiian monarchs and chiefs."[29] They were initially support or mission focused only. Their primary objectives were proselytization and education, a kind of compassionate care or presence. They started by limiting their educational initiatives to Hawaii's leaders and their families and eventually opened them to all islanders. However, after being there awhile, these American missionaries became enmeshed in the cultural and political dynamics of the natives. They saw opportunities to profit and leverage political and economic power for themselves and their country. Then businessmen came in and took over land rights in the agricultural business. As the business grew internationally, natives while considered valuable as sailors in the whaling industry, were considered incompetent and unable to meet the demands of farm hands. Thus, the "haole" or white man, who pressured the kings into granting them control of agricultural interests, started importing Chinese and eventually Japanese laborers for the sugar plantations. This had a tremendous impact on the Hawaii's demographic, politics, and race relations. As mentioned above, the native population decreased to only 40, 000 in 1890 (6,000 of whom had a non-Hawaiian parent) while the non-Hawaiian community increased from 2,000 in 1853 to 50,000 in 1890 with the Haole gaining economic and political dominance.[30] In only seventy years

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[29] Gussow, *Leprosy, Racism, and Public Health,* 88.

[30] Gussow, *Leprosy, Racism, and Public Health,* 91.

since the arrival of the first United States missionaries, their presence both diminished and surpassed the indigenous people. Even this was blamed on the natives. In an 1888 report, the legislature then Board of Health President N. B. Emerson attributed the natives' diminished population size to:

> First, leprosy. Second, the indolent and easy nature of the natives, which causes them to rest content, provided they can obtain the bare necessities of life. They are content to sit idle while their places are being filled by Chinese and their lands are gradually passing from their possession. This apathy causes them degenerate both mentally and physically, and thus leads to the smallness and the gradual extinction of the race.[31]

Further, on June 30, 1887 political alliance known as the Hawaiian League forcibly formed a coup and seized control of the government from then King Kalākaua. It was comprised primarily of white missionaries and businessmen who sought to exploit Hawaii and her people for financial prosperity and politically for her strategic geographic location concerning world affairs. They presented themselves as the Reformed Cabinet (and eventually the Reformed Party) and drafted a new Constitution which literally shifted power from the king to the cabinet. The king was forced to sign it on July 6, 1897. In so doing, he lost the following: the ability to appoint members to the legislature, veto power, control over the military, and ability to approve any constitutional changes. They changed the voting laws to benefit land owning whites and to exclude natives. Moblo writes, "the Reform Cabinet recalled Hawaiians from their studies abroad, strictly enforced leprosy laws, ratified and extended the reciprocity treaty that put Pearl Harbor under American control and refused to limit the importation of the alien labor that kept

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[31] Moblo, "Blessed Damien of Molokai," 80, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

wages low."[32] The Reformed Party was opposed by the National Reformed Party (National Party) who sought only to help the Hawaiians regain autonomy and independence and maintain the rights to farm their own land. It was in this polarized and politically heated context that Father Damien served in Molokai when leprosy became weaponized as a partisan issue.

On September 11, 1888, the New Legislature by-passed the king to initiate new enforcements to the laws concerning leprosy. The so called "Act to Facilitate the Segregation of Lepers" did three things. First, it prohibited passenger ships from transporting lepers and those with other contagious diseases. Second, it made assisting or concealing persons with leprosy a misdemeanor carrying fines from $10.00 to $200.00. Third, the new law gave the board the authority to declare a leper's family members who served as helpers to be lepers themselves solely on the grounds of exposure.[33] This was the case whether they showed signs of leprosy or not. The law demanded police to turn those suspected of leprosy over to the board of health. They were then taken to a receiving station in Honolulu where they were diagnosed. If they were found have leprosy, they were shipped to Molokai. If not, they were released. No provisions were made for the families of the deposed. They often had to rely on family or fend for themselves. If the family could afford it, they were expected to pay towards the building of shelter for their loved one at Molokai. In other words, although leprosy was the least dangerous of the prevalent illnesses of the times, and while the transmutability question

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[32] Moblo, "Blessed Damien of Molokai," 77, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

[33] Moblo, "Blessed Damien of Molokai," 78, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

was unresolved, the new legislature and Hawaii's Board of Health used it as a political tool of bigotry and oppression to justify their political and economic exploitation of the people and their land. Further, because the affected were primarily Hawaiian, the members of the board assumed that the hygiene, diet and sexual habits of the natives increased contagion and made them more susceptible to disease. This kind of stigmatization resulted in natives being type casted as heathens who lack proper protestant ethics. By means of systemic racism, they became the perceived culprits behind this "manufactured" leprosy crisis.

Obviously, this was not received well by the natives. Moblo writes, "the greatest obstacle to carrying out the law of segregation was the 'fatal sentimentality' behind the bitter and persistent antagonism of the Hawaiians, who did not appreciate, and refused to be convinced, that leprosy is a communicable disease, [and] that the leper is unclean and should be shunned, as the bearer of a deadly contagion."[34] Hawaiian families adamantly rejected the so called 'Contagion Theory" as defined by the new law which made having the disease or caring for leprous family members criminal. Theirs was a very close knit, supportive, family-oriented culture. They could not fathom the idea of indefinitely imprisoning and rejecting loved ones just because they contracted a disease. No, they embraced, nurtured and cared for their sick. They resisted the new law. One month after the law of compulsory segregation went into effect Kohala physician, B. D. Bond, reported that all possible leprosy suspects had "gone into hiding."[35] They hid in

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[34] Moblo, "Blessed Damien of Molokai," 81, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

[35] Moblo, "Blessed Damien of Molokai," 80, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

mountains and in caves. One man, John Mia, of Maui even took up armed resistance and threatened violence toward any man who tried to take him to Molokai. Nonetheless in 1888, the law led to 321 people being banished to Molokai as compared to only twenty-eight the year before.[36] The Board's plan was to temporarily set the lepers up with housing, clothing, food and land with the expectation that in time they would be able to fend for themselves. They believed that the strong would help take care of the weak and as a community they would become self-sufficient. The government was also supposed to provide medical treatment for the victims. This is not what actually happened. In his article, "A Leper for Christ: St. Damien of Molokai and Solidarity," author Brandon Vogt observed that "once the lepers were out of sight and no longer a threat to the general population, the government turned a blind eye to their basic needs. Shipments of food and supplies slowed down, and the government removed most of its personnel. The result was a highly dysfunctional community marked by poverty, alcoholism, violence and promiscuity."[37]

It was specifically to combating this heinous disease and serving these unfortunate souls that Fr. Damien would commit his life. It was not that Fr. Damien was oblivious to the racial and economic bigotry going on around him, his focus was primarily on his ministry, on providing compassionate care for the lepers. His limited interactions with the government or the Board of Health were somewhat contentious as he was a strong advocate for the lepers.

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[36] Moblo, "Blessed Damien of Molokai," 82, accessed August 10, 2018, https://eds.b.ebscohost.com/eds/pdfviewer/pdfviewer?vid=2&sid=755c87ff-5077-4afa-94c3-72ddbad61126%40sessionmgr102.

[37] Brandon Vogt, "A Leper for Christ: St. Damien of Molokai and Solidarity" (blog), Word on Fire, May 10, 2016, 1-5, accessed August 1, 2018, https://www.wordonfire.org/resources/blog/a-leper-for-christ-st-damien-of-molokai-and-solidarity/19366/.

When Father Damien arrived in Molokai in May 1873, he found the living conditions among the lepers colony there deplorable. As a young, benevolent, and courageous missionary he was ill prepared for his sudden immersion into the dismal and hopeless world of these banished sufferers. Farrow describes the scene of lepers who gathered to greet him upon arrival on the shores Molokai as follows:

> It was hard to feel any kinship with the live things that surrounded him. They were without faces or if they had faces they were distorted beyond resemblance to any human shape. Where eyes has been there were craters of pus; and there were gaping cavities, disease infected holes that merged with rotting mouths, where noses should be. Ears were pendulous masses many times their natural size, or were shriveled to almost nothing. Hands were without fingers and some and some arms were merely stumps. Feet and legs were equally repulsive and the bodies of most of them were bloated and pitted, shrunken and swollen, but never of a normal shape. They were a pitiable, revolting sight; their wounds and sores being undressed or covered with filthy matter-soaked rags.[38]

Moreover, Vogt observed that "at first, the conditions around the lepers proved overwhelming. Damien often felt as if he had opened the doors of hell. Victims wandered about, their bodies in ruin and their constant coughing the inland's most familiar sound."[39] Despite having received strict orders from his superiors not to associate too closely, or touch, or eat with the lepers, Damien was determined to blend into their community by "becoming one of them." This first meant overcoming the often putrid smell that accompanied the rotting flesh of advanced stage lepers. Damien once reflected, "Many a time in fulfilling my priestly duties at the lepers' homes, I have been obliged, not only to close my nostrils, but to remain outside to breathe fresh air. To counteract the bad smell, I myself accustomed to the use of tobacco. The smell of the

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[38] Farrow, *Damien the Leper*, 32.

[39] Vogt, "A Leper for Christ," 2, accessed August 1, 2018, https://www.wordonfire.org/resources/blog/a-leper-for-christ-st-damien-of-molokai-and-solidarity/19366/.

pipe preserved me somewhat from carrying in my clothes the obnoxious odor of our lepers."[40]

According to author John Milsome in his book, *Damien: Father to the Lepers,* there were approximately 800 lepers at Molokai when Damien arrived.[41] The physician visited only once every other month and administered very little, if any relief. Not wanting to have contact with the lepers, he would even change their bandages with a stick. The food rations were minimal. They were given a nominal monthly allowance restricted to shopping at government owned stores which sold food products produced by companies in which members of the legislature and board of health owned stock. Their homes were comprised primarily of tree leaves and branches. Their clothes were rags, and the water supply minimal. It was the kind of loathsome and abject poverty and despair that would reduce rationale people to an animal-like survival of the fitness kind of existence.[42]

From the start, Father Damien offered compassionate care. Milsome describes it this way, "Damien identified himself with these poor lepers. He was their champion: he fought ceaselessly for their rights. He was a father and friend: he was totally available to help them in all their needs, from lifting broken spirits to bandaging leprous sores, from organizing musical and sporting events to making coffins and digging graves."[43] All of his life experiences from Louvain came to bear on this last and most worthy assignment.

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[40] Vogt, "A Leper for Christ," 2, accessed August 1, 2018, https://www.wordonfire.org/resources/blog/a-leper-for-christ-st-damien-of-molokai-and-solidarity/19366/.

[41] John Milsome, *Damien: Father to the Lepers* (Ann Arbor, MI: Servant Publication, 1989).

[42] Milsome, *Damien*, 34.

[43] Milsome, *Damien,* 34.

He built houses, founded new water sources and worked to build piping and a system to channel it to the leper's colony. Like a physician, he dressed their wounds. He assumed the roles of the coffin maker, priest and undertaker. He was even their self-appointed ombudsman.

For Milsome, Damien was no social worker pretending to be a priest, he was merely a priest who cared for both the spiritual and material needs people.[44] Damien made no difference between himself and the lepers. He not only touched them, he lived among, ate with and identified with them. In a letter written to his brother Fr. Pamphile, Fr. Damien once wrote of his life at Molokai, "…as for me, I make myself a leper, to gain all to Jesus Christ. That is why in preaching I say, We lepers, not my brethren as in Europe."[45] Father Damien contracted leprosy and after dedicating his life to serving the lepers of Molokai for sixteen years, he died at the age of forty-nine. Over his grave a black marble cross was placed engraved, "Sacred to the memory of Rev. Father Damien de Veuster. Died a Martyr to the charity of the afflicted lepers. April 15, 1889."[46] The Holy Bible says, "Greater love has no man than this that a man lay down his life for his friend" (Jn. 15:13). History has revealed that there is no such thing as a perfect man, but Fr. Damien was willing to sacrifice all for the "least of these," and that makes him worthy of reverence. What an excellent model of compassionate care. Where did that kind of compassion and self-sacrificial love come from? We now turn our attention to a possible

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[44] Milsome, *Damien,* 35.

[45] Milsome, *Damien,* 34.

[46] Milsome, *Damien,* 94.

source of inspiration for this hallowed Saint of the Roman Catholic tradition – the teaching of the church itself.

Hawaii was not Father Damien's first exposure to leprosy. It should be remembered that Damien was from Belgium, a province of the northeastern Roman Empire. It should also be recalled that as a child Fr. Damien and his siblings were well educated in the history and traditions of the church. They were so moved or impressed with these that all three of them sought careers in religion and two of them sacrificed their very lives therein. Therefore, a review of ancient Roman Catholic teachings and responses to leprosy may prove insightful. In an article entitled "Medieval Leprosy Reconsidered," authors Timothy Miller, and Rachel Smith-Savage challenged the long held belief that Medieval Christianity rejected and sought compulsory segregation of lepers into Leprosarium's or Lazar Houses as a means of punishment.[47] The prevailing belief was that lepers contracted the illness as a result of sinful living and were thus deserving of being permanently ostracized in compliance with Levitical Law. Accordingly, they were to be "driven outside the camp." In this view, Lazar Houses functioned more like jails or asylums of forced isolation. Medical Historian Stephen R. Miller summarizes this understanding in the following quote, "In the High and later Middle Ages, the leper was legally and religiously cut off from the rest of society. He

[47] Timothy S. Miller and Rachel Smith-Savage, "Medieval Leprosy Reconsidered," *International Social Science Review* 81, no. 1/2 (2006): 16-28, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

was seen as morally unclean. Special hospitals served to segregate lepers. Fear of the disease, religious impulses, and social attitudes combined to create this situation."[48]

Miller and Savage reject this understanding of medieval Christianity's response to the leprosy problem on the grounds that it is a misrepresentation of the true historic church's teachings and practices towards lepers. They believe that modern scholarship's failure to adequately incorporate primary Greek sources on the subject has led to an unfortunate distortion of church history on the subject of leprosy. They write, "...modern scholars have often failed to understand the earlier Greek texts in their proper context. As a consequence, they have been unable to adequately reconcile them with later statements on leprosy in the Latin documents of the Middle-Ages."[49] They base their arguments on the writings and teaching of ancient Greed physicians and the Patristic fathers of the Christian faith from the fourth and fifth centuries and the establishment of Lazar Houses.

Ancient Greek physicians like Aretaios and Galen who were among the first to write about and treat leprosy around the first and second century. In AD 150, Aretaios offered the first accurate description of leprosy. He wrote about the skin blotches and fissures, the discoloration, hair loss, and loss of fingers and toes. For Aretaios death was a gradual process that resulted in the cooling of black bile (one of the four major fluids in the body according to Greek medicine). He was also the first to refer to leprosy as

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[48] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 19, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

[49] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 20, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

"debilitating state between life and death" a kind of living death.[50] This understanding of leprosy as a "living death" was then adopted by patristic writers who used it to arouse sympathy and compassion for plight of lepers.

Accordingly, Gregory, Bishop of Nyssa in Asia Minor during the 370s taught on the subject of leprosy in a way that even expanded Aretaios's description to include a raspy voice, and loss of sensation to affected skin (symptoms prominent in Farrow's description of Father Damien's leprosy over 1400 years later). He also went to great lengths to describe the public scorn and rejection suffered by lepers and attempted to correct this from a Christocentric prospective. Summarizing his argument Savage and Miller write, "He stressed, however, that Christ expected his followers to help these most wretched of human beings. By accepting lepers, by feeding them, by embracing them, even physically, Christians merited salvation.[51]"

Further, Gregory of Nazianzos, a friend and contemporary of Nyssa's wrote an even more extensive treatise on leprosy. He taught that Christians have an obligation to offer compassionate care and assistance to lepers. He specifically refuted and condemned the teaching that leprosy was a punishment from God. He reminded his readers that the biblical narrative of Job teaches that it is impossible to comprehend why God acts as he does, much more so in the case of lepers. He suggested that even Job's infliction was a kind of leprosy and challenged Christians to name his sin. He cautioned

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[50] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 20, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

[51] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 20, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

all Christians to refrain from any vain attempts at unraveling the mystery of God's permissive will. Essentially, he believed that ours is not to fathom why, but to be a willing extension of His love and grace.[52]

Moreover, from 412-444 AD Cyril, the famous Bishop of Alexandria further extended the Christian view of leprosy by reinterpreting Mosaic Law. Savage and Miller summarized his teachings as follows:

> On the one hand, the Old Testament banned lepers from the camp, but on the other hand, it provided a complicated set of rituals including the sacrifice of a dove which a leper should perform if he/she were healed and sought readmission to society (an indication that Old Testament leprosy was not what Aretaios, Galen, and subsequent medieval society identified as a disease which was incurable). Cyril stressed that Christians should never interpret these Old Testament laws literally because it would be an evil act to ban lepers from society; these people deserved mercy not rejection. Cyril interpreted the passage allegorically: leprosy was sin and the sacrificed dove Christ's saving death on the cross.[53]

Essentially, Cyril agreed with both Nyssa and Nazianzos that Christians should assist victims of leprosy, not reject them. This offers a great example of divine grace meeting humanity at a place of vulnerability and abandonment. It was this understanding of the church as a source of grace and compassionate care for the disparaged and marginalized that not only influenced Roman Catholicism, it laid the foundation for the modern-day healthcare. Professor Louise Cilliers in her article, "The Evolution of the Hospital from Antiquity to the end of the Middle Ages," also credits this period with the founding of the

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[52] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 21, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

[53] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 21, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

modern hospital era.[54] She asserts that the Christian attitude towards the sick was inspired by biblical narratives like the Good Samaritan which encourages a show of "mercy and compassion towards everyone.[55]" She further argues that this ethos of compassion did not find full expression until the emperor Constantine promulgated his famed "Ethics of Toleration" in 311 and 313 which allowed religious freedom. This paved the way for more publicized or outreach oriented expressions of the Christian faith. While the early church's outreach initiatives involved various groups of people, pilgrims, the poor, and those suffering various illnesses, its focus was primarily on its response to leprosy in "Lazar Houses."

The Lazar Houses of the late fourth century were initially built to shelter pilgrims, ecclesiastical messengers, as well as, the mentally and physically infirm. They were usually attached to and supported by monasteries as functions of Christian Charity. It was in these shelters that lepers found support and affirmation. For example, in the eastern Roman Empire, John Chrysostom, Bishop of Constantinople (395-404) built and established a large leprosarium outside the capital. He called it a "*xenodochin,*" the Greek word for hospice. Miller and Savage observe that, "He planned this institution not to isolate lepers but to give them a healthy place to live near a river, and to offer them all

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[54] Louise Cilliers, "The Evolution of the Hospital from Antiquity to the Middle Ages," *Curationis* 25, no. 4 (November 2002): 60-66, accessed August 1, 2018, https://eds.b.ebscohost.com/eds/detail/detail?vid=4&sid=833261b5-a80e-4535-b34c-902266595bb6%40sessionmgr103&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsair.doajarticles..660616b3933f77e66f09e2467b22e588&db=edsair.

[55] Cilliers, "The Evolution of the Hospital from Antiquity to the Middle Ages," 63, accessed August 1, 2018, https://eds.b.ebscohost.com/eds/detail/detail?vid=4&sid=833261b5-a80e-4535-b34c-902266595bb6%40sessionmgr103&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsair.doajarticles..660616b3933f77e66f09e2467b22e588&db=edsair.

the benefits of a home and communal."[56] Further, in the western church, Saint Jerome, a monk of the Roman Church, wrote about a wealthy Roman woman named Fabiola who in 390 AD, seeking absolution by spending her money on charity, built what some believe to be the first hospital in Rome. St. Jerome described her patients as, "...those with distorted feet, inflamed complexions, and truncated noses, people whose blood had become turgid, i.e. muddy with the black bile of leprosy. Miller and Savage report that she became so moved by the plight of lepers that she even resorted to personally washing their "oozing flesh.""[57] Again, this is reminiscent of Father Damien's acts of compassion towards the lepers of Molokai. Lazar Houses began to decline sometime around the sixth and seventh centuries in Europe only to reappear in greater numbers after the crusades.

Moreover, by the seventh century the term *"xenodochein"* (hospice) used to describe the monostatic period's ministry of providing shelter and medical care to society's marginalized gave way to the Latin term *"hospitalium."* Cilliers observes that from *"hospitalium"* or *"hospitalia"* we get the English words "hospital" "hotel" and "hospice[58]." With the founding of the famed monastery and hospital at Monte Casino in Italy in 529, St. Benedict of Nursia is believed to have launched one of the most influential of all medieval initiatives in healthcare when he insisted on excellence and

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[56] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 21, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

[57] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 21, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

[58] Miller and Smith-Savage, "Medieval Leprosy Reconsidered," 20, accessed August 13, 2018, https://eds.a.ebscohost.com/eds/results?vid=0&sid=9fe00804-620b-4bbb-8ea7-98d317e3f245%40sdc-v-sessmgr02&bquery=medieval%2Bleprosy%2Breconsidered&bdata=JmNsaTA9RlQxJmNsdjA9WSZ0eXBlPTAmc2l0ZT1lZHMtbGl2ZQ%3d%3d.

commitment in the care of illness. His so-called Benedictine Rule called for the establishment of an infirmary in every monastery in which care for the sick was seen as a "primary duty."[59] This was later supported by a 742 Church Council which decreed all monks and nuns should run their lives, monasteries, and hospitals according to the Benedictine Rule.

During the tenth and twelfth centuries during Europe's infamous leprosy epidemic there were reportedly over two-thousand Lazar Houses in France and hundreds of others all over Europe. The point is that the original Christian response to leprosy was not to retreat to ancient biblical notions of exclusion and rejection, but one of compassionate care as a primary Christian ethic. Services were initially focused on leprosy, but expanded to include those suffer other illnesses, the poor and travelers. In fact, Farrow and others, credit these Lazar Housed and the Black Plague with helping to stamp out leprosy in Europe. It is therefore very possible that these stories about the heroes and heroines of faith, these exemplars of compassionate care and self-sacrificial service towards others helped shape and mold Damien's ministerial perspective. Perhaps, the stories about St. Damien and his twin brother, about the patristic writers, about the monks and nuns, and martyrs who gladly sacrificed all to help the "least of these," served as a source of inspiration to Fr. Damien. Perhaps these made up the substance of the many stories of church history that Damien's mother read to her three younger children. Perhaps, this is what inspired all three of them into a life of religious service. Surely as a young novitiate in seminary, he would have encountered the patristic writers and their

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[59] Cilliers, "The Evolution of the Hospital from Antiquity to the Middle Ages," 64, accessed August 1, 2018, https://eds.b.ebscohost.com/eds/detail/detail?vid=4&sid=833261b5-a80e-4535-b34c-902266595bb6%40sessionmgr103&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsair.doajarticles..660616b3933f77e66f09e2467b22e588&db=edsair.

views on leprosy. As we shall see below, the Christian ethic of compassionate care did not just affect the life of Father Damien de Veuster, it impacted the world for generations to come including the modern hospice movement.

Hospice is a special branch of healthcare that focusses primarily on palliative or comfort care for terminally ill patients and their families. Its purpose is to treat symptoms so as to minimize pain and suffering, offering peace and dignity to the dying process. The first hospice, St. Joseph's Hospice was opened on January 15, 1905.[60] It was operated by the Irish Sisters of Charity. Like the Lazar Houses of old, their mission was to provide care for the sick, terminal, and in the poor section of London. With the support of the church and benevolent supporters, the hospice provided compassionate care for dying people. They even provided breakfast for the needy during periods of high unemployment and harsh weather. In 1958, St. Joseph's opened its doors offering a young social work student named Cicley Saunders a venue in which to complete her clinical studies. She would later become the founder of the modern hospice movement. She later founded St. Christopher's Hospice in London, England on July 24, 1967[61].

Through her experiences at St. Joseph's, Saunders grew to foster a deep sensitivity to, and respect for the needs of the terminally ill. She was particularly critical of traditional healthcare practices toward dying patients. She was concerned that patients and families were subjected to inadequate care which denied them the dignity of holistic treatment throughout the dying process. They were not getting truthful diagnoses, or

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[60] St. Joseph's Hospice, "Our History," St. Joseph, accessed August 15, 2018, http://www.stjh.org.uk/about-us/our-history.

[61] St. Joseph's Hospice, "Our History," accessed August 15, 2018, http://www.stjh.org.uk/about-us/our-history.

effective pain management. Their emotional, social and spiritual needs were being ignored. Underlying her beliefs was her a very strong faith in God. Saunders was a committed Christian whose faith weighed heavily in her sense of calling to healthcare. Desiring a stronger voice as an advocate for the terminally ill, she returned to school becoming both a nurse and a medical doctor. In his article, "Religion, Medicine, and Community in the Early Origins of St. Christopher's Hospice, Dr. David Clark writes, "She studied medicine as a third profession specifically to do something about the problem of pain in patients dying of cancer."[62]

Saunders expanded healthcare's understanding of pain to include spiritual, and emotional factors. She revolutionized end-of-life care by introducing the idea of an interdisciplinary team approach. As mentioned above, the focus of hospice care is palliative care, otherwise known as comfort-care. Unlike the more traditional curative form of patient care which focuses primarily on curing some chronic illness, palliative care's primary emphasis is symptom management. That is, hospice concerns itself with the comfort level of the patient and family so as to offer as much comfort, peace, and dignity as possible. For Saunders, the whole philosophy of hospice care is best captured in the following quote, "You matter because you are you. You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to

[62] David Clark, "Religion, Medicine, and Community in the Early Origins of St. Christopher's Hospice," *Journal of Palliative Medicine* 4, no. 3 (2001): 353-360, accessed August 13, 2018, https://eds.b.ebscohost.com/eds/detail/detail?vid=2&sid=b12600d9-3053-4ed3-94e6-df19dfa1ab14%40sessionmgr104&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=RN102659508&db=edsbl.

live until you die."[63] To emphasize the role of faith in the founding of the modern hospice movement, Clark writes the following:

> St. Christopher's Hospice is defined as a religious foundation based on the full Christian faith in God. Five underlying convictions are listed: (1) all persons who serve in the hospice will give their own contributions in their own way; (2) dying people must find peace and be found by God, without being subjected to special pressures; (3)"love is the way through," given in care, thoughtfulness, prayer, and silence; (4) such service must be group work, led by the Holy Spirit, perhaps in unexpected ways; (5) the foundation must give patients a sense of security and support, which will come through a faith radiating out from the chapel into every aspect of corporate life.[64]

In 1971, Saunders was invited to lecture at Yale University on Palliative Care to terminally patients and their families. This led to the establishment of the Hospice Inc. in and the founding of the first American hospice, the Connecticut hospice in 1974. Vitas Healthcare (formerly Vitas Innovative Hospice) was founded four years later in 1978. In 1982, Hospice Medicare Act was passed making a hospice services a provision of the federal government. Dame Cicely Saunders died on July 14, 2005 at St. Christopher's Hospice in London.[65] Like Father Damien, the patristic writers, and many others she leaves a very strong heritage of compassionate care to society's vulnerable.

Compassionate Care is patient care that often comes at great personal sacrifices. Interestingly, throughout this study no mention has ever been made of the need to care for

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[63] "History of Hospice: A Historic Perspective," National Hospice and Palliative Care Organization, accessed September 17, 2018, http://www.nhpco.org/history-hospice-care.

[64] Clark, "Religion, Medicine, and Community," 358, accessed August 13, 2018, https://eds.b.ebscohost.com/eds/detail/detail?vid=2&sid=b12600d9-3053-4ed3-94e6-df19dfa1ab14%40sessionmgr104&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=RN102659508&db=edsbl.

[65] Clark, "Religion, Medicine, and Community," 358, accessed August 13, 2018, https://eds.b.ebscohost.com/eds/detail/detail?vid=2&sid=b12600d9-3053-4ed3-94e6-df19dfa1ab14%40sessionmgr104&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=RN102659508&db=edsbl.

the caregivers making these sacrifices. How do we take care of the emotional, spiritual, educational, and physical needs of the caregiver? Failure to address these needs in employees constitute a kind of institutional or systemic abandonment or neglect on the part of the employer. This leaves employees vulnerable to stress related emotional or psychological illness like compassion fatigue and burnout.

Preventing or addressing the concerns raised by issues like compassion fatigue and caregiver burnout is the primary focus of this project. The physical stress, emotional strains, social challenges, and spiritual isolation suffered by great caregivers like Fr. Damien were, for the most part borne alone. Of the things that Farrow reports, Fr. Damien longed for the most were collegiality, friendship, and someone to hear his confessions. This was because of the segregation laws concerning lepers which prohibited constant contact with the outside world. In fact, he was so desperate for this that he even resorted to saying his penitence from a smaller boat to a priest on a steamer because as a leper he could not board the steamer. He so immersed himself in helping others that he often neglected his own wellbeing. Father Damien was only forty-nine-years old when he died. Moreover, according to a recent study among occupations, those in healthcare, especially doctors and nurses have a 50% higher suicide rate than others. I believe that burnout and fatigue become even more likely for those who spend forty or more hours per week dealing specifically with death and dying. This is especially true for those field-based hospice workers who (like Fr. Damien) spend most of their work week working in isolation directly with patients and families with no outlet or means of processing their experiences or getting clinical support. This is especially important to me because of his own life's struggles with the long-term challenges and psychosis

related to abandonment. Therefore, the goal of this Doctor of Ministry project is to identify those factors that contribute to these phenomena and to develop a systemic remedy to them. Since the context is a hospice program, the focus will be limited to a small study group comprised of certified nursing assistants, nurses, a social worker, and a chaplain. It is hoped that risk factors are identified and a curriculum developed to address these in a way that has far reaching implications beyond healthcare to all social service, or ministerial contexts where people are daily in the spirit of Saint Damien deVeuster offering compassionate care to the "least of these."

CHAPTER FOUR

THEOLOGICAL FOUNDATIONS

Most will agree that the desire for survival or self-preservation is a universal human trait. Yet, mortality has its limits and the very thought of dying is unnerving for most people. Death is not only one of life's greatest denominators, it is also uniquely revealing. It lays bare one's true character, ulterior motives, and heart-felt convictions. Like the surgeon's scalpel it peels back our facades, unmasks our vulnerabilities and reveals our true selves: our fears, hurts, angers, and dysfunctions and true ambitions. In the case of Molokai, Fr. Damien de veuster, and the so-called leprosy epidemic with its reported threats of contagion and death exposed the hidden agendas of both Protestant missionaries and business classes alike. It exposed the systemic exploitation of the disease towards their own economic and political ends. In other words, death as symbolized by leprosy, became to them an unjust means to a corrupt and unethical end; to wealth and power. It is dumbfounding how Christian missionaries so readily abandoned their religious convictions and missions when they realized the vulnerabilities of the naïve and trusting natives. The same can be said of Protestants and Roman Catholics alike during the rise of Hitler and the Nazi regime in Germany between 1933 and 1945. Again, being confronted with the very real and threatening possibility of danger, and in some cases death, devout Christians began responding in very unexpected

and atypical ways causing many outsiders to question the authenticity or validity of their Christian professions.

Adolph Hitler rose to power as Reich Chancellor on January 30, 1933 ushering in Germany's infamous era of National Socialism; one the most grotesque, inhumane, and destructive chapters' of European history.[1] Just after he assumed power Hitler started issuing one decree after another chipping away at the public's constitutional liberties while deceptively pretending to be protecting its national interests.[2] The most ominous decree of all was an 'emergency decree' initiated only one month into his Chancellorship on February 28, 1933, called the "Reich's President Edict for the Protection of People and State." It, in effect, vanquished many cherished constitutional freedoms of German citizens giving Hitler absolute autocratic power. It reads in part, "Therefore restriction of personal freedom, or the right of speech, including the freedom of the press, of the association and of public assembly, intervention in the privacy of post, telegraph and telephone, authorization of house searches and the confiscation of property, beyond the hitherto legal limits, will henceforth be admissible."[3]

The edict paved the way for Hitler's vicious agenda of opening concentration camps and the eventual systemic extermination of Germany's Jewish population. On April 7, 1933, in only his fourth month in office, Hitler's government passed another law to reinforce National Socialism called "the Law for the Restoration of the Professional Civil Service." It contained the infamous "Aryan Clause" which excluded Jews from

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[1] Eberhard Bethge, *Dietrich Bonhoeffer: A Biography* (Minneapolis, MN: Fortune Press, 2000), 257-304.

[2] Bethge, *Dietrich Bonhoeffer,* 263.

[3] Bethge, *Dietrich Bonhoeffer,* 263.

positions in government, universities and churches.[4] Shortly afterwards, the law was expanded to include all Non-Aryan professionals like lawyers, doctors, tax consultants, and notaries. It was the first of many of Hitler's anti-Semitic actions but certainly not his last. The *Kristallnacht* or night of broken glass (or Night of Crystal) occurred on November 10, 1938.[5] It was a night of unparalleled government sanctioned violence against Jews. The windows of Jewish owned homes, businesses and synagogues were smashed, and random violence unleashed against men, women and, children. It resulted in hundreds of deaths and over 30,000 Jews being sent to concentration camps. In one night a reported 7,000 Jewish owned shops and synagogues were either destroyed or burned to the ground.[6] It eventually led to the Holocaust.

Further, according to Matthew D. Hochenos in his article, "The Church Struggle and the Confessing Church: An Introduction to Bonhoeffer's Context," Germany's population size in 1933 was sixty-five million people. The German Evangelical Church accounted for forty-one million of them. The Roman Catholic Church accounted for twenty-one million. Jews were believed to have made up 1% of Germany's population with about a thousand of them being Christian converts.[7] With such a dominant presence in Germany, one would naturally question the Christian Church's response to the Nazi

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[4] Alex Rankin, "Dietrich Bonhoeffer, A Modern Martyr: Taking a Stand Against the State Gone Mad," *The History Teacher* 40, no. 1 (November 2006), accessed January 1, 2019, https://www.researchgate.net/publication/269509782.

[5] Rankin, "Dietrich Bonhoeffer, A Modern Martyr," accessed January 1, 2019, https://www.researchgate.net/publication/269509782.

[6] Geffrey Kelly, "The Church and the Totalitarian State," *Ukrainian Quarterly* 70, no. 1-4 (Spring-Winter 2014): 61, accessed January 4, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048.

[7] Matthew D. Hochenos, "The Church Struggle and the Confessing Church: An Introduction to Bonhoeffer's Context," *Studies in Christian-Jewish Relations* 2, no. 1 (2007): 2-3, accessed February 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

reign of terror. What admonition; what correction; rebuke, or guidance on moral integrity, dignity, and human decency was offered by the collective witness of the church? Famed German theologian Dietrich Bonhoeffer once asked, "Who is Jesus for us today?"[8] In a world of chaos and turmoil what help can or should be expected from the collective voice and witness of the church? Based on the church's responses to the Nazi regime, not much. The Catholic Church had a much more centralized and uniform ecclesiastical structure than their Protestant counterparts in the faith, yet, in July of 1933, Hitler and Pope Pius XI signed a concordat or treaty. Accordingly, "the Roman Catholic Church agreed to refrain from all political activities or publicizing opinions about the government, and in turn the state guaranteed Catholics the right to freely worship, to circulate Pastoral Epistles, and to maintain Catholic schools and properties."[9] However, not all Catholics agreed with the concordat. Prior to the agreement a letter of concern was sent to the Pope by a Jewish convert (1922) Edith Stein. She wrote:

> Everything that happened [in Germany] and continues to happen on a daily basis originates with a government that calls itself "Christian." For weeks not only Jews but thousands of fearful Catholics in Germany, and I believe, all over the world have been waiting and hoping for the Church of Christ [the Roman Catholic Church] to raise its voice to put a stop to this abuse of Christ's name. Is not this idolization of race and government power which is being pounded into the public consciousness by the radio open heresy? ...Is not all this diametrically opposed to the conduct of our Lord and Savior, who, even on the cross, still prayed for his persecutors?[10]

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[8] Andreas Pangritz, "Who Is Jesus Christ, for Us, Today?" In *The Cambridge Companion to Dietrich Bonhoeffer*, ed. John W. de Gruchy (Cambridge, UK: Cambridge University Press, 1999), 134-153, doi:10.1017/CCOL052158258X.008.

[9] Margot Stern Strom, *Facing History and Ourselves: Holocaust and Human Behavior* (Brookline, MA: Facing Ourselves and History Foundation, 1994), 222-279.

[10] Strom, *Facing History and Ourselves,* 2.

The Pope never responded to her letter. She later died in a concentration camp during the Holocaust and Hitler never fully complied with the concordat. Within months of the agreement, SS forces were shutting down Catholic organizations, confiscating property, interfering with Catholic newspapers, imprisoning and even murdering Catholic clergy and church leaders without a peep from the Pope and Church. Things were much not different with the Protestant church.

The "German Evangelical Churches" was an alliance comprised of twenty-eight autonomous regional churches accounting the forty-one million Protestants in Germany. It included Lutheran, Reformed, and United denominations or traditions. The Lutheran and United were the two largest Protestant church alliances. They were also very diverse in their world views especially when it came to Hitler and his Gleichschaltung, the attempt to integrate all German Life (cultural, economic, political, family, social and religion) with the Nazi world view.[11]

Conservative evangelicals tended to be compliant and liberals more resistant to Nazism. Conservatives (aka "the German Christian Movement") generally held world views more aligned with Hitler's. They were ultra-nationalist, anti-Semitic, and pro-Nazi. Their liberal counterparts formed a contentious faction known as the Confessing Church. It is important to note that their primary areas of dissension did not pertain to their world views in general, but the church and its identity. Hochenos further observed that at their social and political core most Confessing Church members actually accepted Hitler's anti-Semitic and destructive polices as long as they did not personally affect them or the

[11] Arthur A. Preisinger, "A Book Worth Discussing: Ernst Christian Helmrich. The German Churches Under Hitler," *Church History* 49, no. 3 (September 1980): 311-315, accessed February 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

church (self-preservation). They were strongly opposed to Hitler's attempts to take over the church. Hochenos writes, "the Confessing Church believed that it was necessary to publicly protest state laws and decrees that interfered with the church's control over its administrative, financial, legal, and pastoral offices."[12] To force the idea of a pro-Nazi United German Church, Hitler appointed pro-Nazi minister Ludwig Muller as the nation's first, "Reich Bishop."

Within one year, Muller and the German Christian Movement gained control over all but three of the twenty-eight regional churches which only widened the divide among the German Christians and the Confessing Church. The ongoing polemics with the German Christians and the State eventually caused tensions within the ranks of Confessing Church, between those whose interests extended no further than church autonomy and self-preservation and those few who were more radicalized, who were concerned with issues of justice and morality. The small group of radicalized Confessors eventually took more extreme actions such as espionage or militaristic activity which eventually led to imprisonment and or death for many of them. One such person was famed theologian and Pastor Dietrich Bonhoeffer.

Today there is great dissention around the person and legacy of Dietrich Bonhoeffer. Some see him as a venerable religious martyr, while others ambivalent about his political activities and legacy, refuse to honor him as a respected Christian leader, and instead relegate him to the category of a political figure, if not a heretic. Therefore, the purpose of this chapter is to take a closer look at Bonhoeffer seeking

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[12] Matthew D. Hochenos, "The Church Struggle and the Confessing Church: An Introduction to Bonhoeffer's Context," *Studies in Christian-Jewish Relations* 2, no. 1 (2007): 7, accessed February 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

insight into the theological premises of his extreme and dangerous behaviors which led to his death at the young age of thirty-nine. Then parallels between Bonhoeffer and Fr. Damien de Veuster to assess whether or not Bonhoeffer's "uncommon valor" can also be called true compassion. Certainly, the treatment of these two men – their struggles with issues of abandonment - are similar. Although hospice workers do not surrender their lives in seeking to serve others, they pay a price for their work. This chapter ends by connecting the insights gained to the growing need for emotional-spiritual support to those employed in the compassionate care industry.

Like Fr. Damien de Veuster, Dietrich Bonhoeffer was born into a very loving, supportive, and financially privileged family. He was born on February 4, 1906 in Breslau, Germany (now Wroclaw, Poland). He had a twin sister, Sabine. They were the sixth and seventh of Paula and Karl Bonhoeffer's eight children. Karl Bonhoeffer was a prominent psychiatrist and neurologist at the University of Berlin.[13] Paula, a college graduate (a rarity for women at the time), was the daughter of the prominent theologian and Chaplain to German Emperor Wilhelm II between1888-1918, Karl Alfred von Hase.[14] Also like, the de Veusters, the Bonhoeffer's were a close knit family who placed great emphasis on early education. Like Fr. Damien's mother, Mrs. Bonhoeffer was her children's primary educator. Dietrich was a very bright young man who was expected to follow his father into the field of psychiatry. However, at the age of fourteen Dietrich announced his interest in becoming a theologian. The Bonhoeffers while Christians, were not very religious in an ecclesiastical sense, and did not respond very

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[13] Rankin, "Dietrich Bonhoeffer, A Modern Martyr," 112, accessed January 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

[14] Bethge, *Dietrich Bonhoeffer*, 5-8.

enthusiastically to Dietrich's announcement.[15] When his father attempted to dissuade him by criticizing the Church as "weak and self-serving," Dietrich is reported to have replied, "If the Church is really what you say it is, then I shall have to reform it."[16] He graduated with his Ph.D. at the age of twenty-one. His dissertation entitled, "Sanctorum Communio," (Community of Saints), was so impressive that reputed Swiss theologian Karl Barth referred to it as a "theological miracle."[17]

After serving as an assistant pastor in Barcelona, Dietrich traveled to the United States where from 1930 to 1931 he studied at the Union Theological Seminary in New York. While there he enrolled in a course entitled, "Ethical Viewpoints in Modern Literature." The course reading list introduced him to the plight of black people in America. It included readings such as: James Weldon Johnson's *Autobiography of an Ex-Colored Man*, and W.E.B. Dubois's *The Souls of Black Folks,"* and poetry by the likes of Langston Hughes and Countee Cullen.[18] Moreover, while at Union Bonhoeffer met and befriended African American student Albert Franklin Fisher, the very connected son of a prominent pastor in Alabama. It was Fisher who introduced Bonhoeffer to the "Black Church." He took Bonhoeffer to visit famed African American church, Abyssinian Baptist, where the legendary minister and civil rights leader Adam Clayton Powell, Sr. was pastor. Bonhoeffer was captivated by Powell and would later adopt some

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[15] Bethge, *Dietrich Bonhoeffer*, 34-44.

[16] Rankin, "Dietrich Bonhoeffer, A Modern Martyr," 112, accessed January 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

[17] Rankin, "Dietrich Bonhoeffer, A Modern Martyr," 112, accessed January 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

[18] Louis Porter, "An Unlikely Alliance: Adam Clayton Powell, Sr., Dietrich Bonhoeffer and the Seeds of Transformation," *Cross Currents* 64, no. 1 (March 2014): 119, accessed February 24, 2019, https://journals-ohiolink-edu.ezproxy.uakron.edu:2443/pg_200?::NO:200:P200_ARTICLEID:317787763.

of his teachings into his own ethics like the call for Christians to resist "cheap grace" in a "world come of age" because they love Jesus, phases often recited by Powell from the pulpit.[19] Bonhoeffer was reportedly so captivated by the black church ethos that he stayed and volunteered teaching a boys' Bible study for almost a year. In fact, in his book," *In Living Faith: How Faith Inspires Social Justice*" author Cutiss DeYoung reflects that Bonhoeffer "eagerly immersed himself in many aspects of the African-American experience of the 1930s."[20] He notes that in addition to Abyssinian, Fisher also introduced Bonhoeffer to African-American communities in Philadelphia, Pennsylvania, and Washington D.C. including Howard University a Historically Black University. It was during such a trip that Bonhoeffer got a first-hand taste of racism as a restaurant refused to serve him and Fisher because of Fisher's race. On American racism Bonhoeffer would later reflect, "It is a bit unnerving that in a country with so inordinately many slogans about brotherhood, peace, and so on, such things still continue completely uncorrected."[21]

It is believed that the "Black Church" experience awakened Bonhoeffer making him more sensitive to issues of racism and social injustice. Concerning Abyssinian Rankin writes, "This experience caused Bonhoeffer to see the growing racism against the Jews in his own country in a new light." Rankin suggests that, he began to believe that Christians should be committed to social and racial justice for those whom society looked

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[19] Porter, "An Unlikely Alliance," 120, accessed February 24, 2019, https://journals-ohiolink-edu.ezproxy.uakron.edu:2443/pg_200?::NO:200:P200_ARTICLEID:317787763.

[20] Paul Curtis DeYoung, *Living Faith: How Faith Inspires Social Justice* (Minneapolis, MN: Fortress Publishers, 2007), 27.

[21] DeYoung, *Living Faith,* 25-47.

down on.[22]" In fact, DeYoung quoting author Reggie Williams' book, *Christ-Centered Empathic Resistance, the Influence of Harlem Renaissance Theology on the Incantational Ethics of Dietrich Bonhoeffer*, writes:

> As a German coming of age during the First World War, Bonhoeffer was familiar with post-war suffering, and the shame of having a negative assessment assigned to his nation identity… At some level, he could empathize with African-Americans, as well as Jews of his era who had shame attached to their identities…The experience of seeing through others' experience and contexts provided him with the ability to respond with insight to the social, political, and theological crises that were engulfing Germany upon his return home from New York in 1931. Hence the narrative of Bonhoeffer's time in New York is a story of transformation. I am using the narrative of Bonhoeffer's New York transformation to illustrate my claim that the Christian ethics we derive from a hermeneutic of Jesus can aid in the struggle against oppression and injustice only when we are capable, like Bonhoeffer, of overcoming our biases and emphatically entering into the situation of another with the ability to reflect on the other's experience.[23]

Upon his returned to Germany in 1931, he was ordained a pastor in the Lutheran Church and began teaching at Berlin University. He took a bold and decisive stance against National Socialism after Hitler's installation as Chancellor. In response to the new oppressive and discriminatory laws, Bonhoeffer made his first public anti-government speech in April of 1933. In the lecture he called the Church to fight political injustice in three ways: 1) to question state injustice and call the state to responsibility, 2) to help victims of injustice whether they were church members or not, and 3), to "fall into the spokes of the wheel itself in order to halt injustice."[24] He also left his position at the university due to the Aryan Clauses refusing to work anywhere his non-Aryan colleagues

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[22] Rankin, "Dietrich Bonhoeffer, A Modern Martyr," 112, accessed January 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

[23] Porter, "An Unlikely Alliance," 119, accessed February 24, 2019, https://journals-ohiolink-edu.ezproxy.uakron.edu:2443/pg_200?::NO:200:P200_ARTICLEID:317787763.

[24] Bethge, *Dietrich Bonhoeffer*, 274-275.

were not welcomed. In 1934, Bonhoeffer joined the Confessing Church's resistance movement. However, because his views were considered extreme and dangerous, he was somewhat marginalized in the Confessing Church. In 1936, the Nazi government declared him a Pacifist and Enemy of the State. In 1938, he was forbidden to live or work in Berlin. In 1939, his friends and family were worried about his well-being and encouraged him to return to the safety of America where he could teach and earn a living. Bonhoeffer took a position with Union Theological in June of 1939, but this was short lived. Feeling guilty for abandoning his work in Germany, he once wrote, "I have made a mistake coming to America… I will have no right to participate in the reconstruction of Christian Life in German after the war if I do not share the trails of this with war my people."[25] He returned to Germany to an almost certain death a month later in July of 1939. Writer David Gushee in an article entitled "Following Jesus to the Gallows" reflected on this courageous decision. He wrote, "The image of Bonhoeffer boarding ship, voluntarily preparing to sail back – straight into the hell that Germany had become, into resistance, into the great likelihood of his own death- is an unforgettable scene and a poignant moment in the history of the Church in the twentieth century."[26] He joined the Abwehr, a German government intelligence agency. His task was to use his contacts through his travels and work with the World Council of Churches to get information on the plans of strategies of Allied Forces. However, he became somewhat of a double-

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[25] Rankin, "Dietrich Bonhoeffer, A Modern Martyr," 114, accessed January 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

[26] David P. Gushee, "Following Jesus to the Gallows," *Christianity Today* 39, no. 4 (April 1995): 30, accessed February 23, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=2&sid=2a8873f3-b5e0-49e7-8478-6cd3feb302e7%40sessionmgr102&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=503287058&db=brb.

agent and was actually feeding Allied Forces information about the Germans. In 1943, he even brazenly participated in an attempt to assassinate Hitler. The plot was unsuccessful leading to Bonhoeffer and others' arrest in 1943 and eventual execution in the Flossenbürg concentration camp. He was only thirty-nine years old.[27] A couple of important questions arise from this brief historical sketch of Dietrich Bonhoeffer. First, why would someone from such a privileged and esteemed background, with so much going for him, risk it all for a cause that had no apparent direct impact him? Second, what prompted a Lutheran pastor and theologian to align himself with such a violent and extreme political faction? This answers to these questions necessitate an exploration of some of Bonhoeffer's key theological beliefs, particularly as they apply to Christ, the world and the Church.

The theme of continuity running through all of Bonhoeffer's theological works from his dissertation *Community of Saints* (1927) to the *Letters and Papers from Prison*, in a gradually evolving fashion was his emphasis on Christocentrism. In his book *The Theology of Dietrich Bonhoeffer* author Ernst Feil referring to Bonhoeffer's Christology writes:

> For Bonhoeffer a theology this Christocentric is one that is bound to the event of God's becoming human in Jesus Christ, the absolute mediator. Every feasible theology is Christology for Bonhoeffer, and since Christ is both man and humankind and exists not for himself or the individual but for all, every such theology is also ecclesiology. Rather than leading away from God this the only way to reach Him.[28]

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[27] Rankin, "Dietrich Bonhoeffer, A Modern Martyr," 114, accessed January 21, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048.

[28] Ernst Feil, *The Theology of Dietrich Bonhoeffer* (Philadelphia, PA: Fortress Press, 1985), 59-81.

For Bonhoeffer, Christ is the wheel in the middle of the wheel from which everything else emanates. He is the center and everything else comprises the spokes in the wheel. Christ is the great boundary between God and all concrete and abstract reality. He is the mediator of everything and everyone in the universe. In this position, Christ is the only way for human beings to know or access God and one another. Bonhoeffer also rejected any attempts to approach the mystery of God from historic epistemological or intellectual means. He insisted God is beyond knowing. Bonhoeffer limited access to the mysteries of God in Christ to the church, the proclaimed word and the sacraments. Bonhoeffer believed that only way the church can actually become an authentic community of believers (the Body of Christ), is through a personal relationship with Christ. He rejected Christological constructs that separated the historical Jesus from the one worshipped in the faith community. He identified Jesus as one and the same; the one who was incarnate, who served, suffered, died and was resurrected. He is at one and the same time the transcendent boundary, deputized to mediate all things Godward. He stands in the middle between God and a fallen humanity. Christ is humanity's only bridge to God and to one another.[29] Feil writes that according to Bonhoeffer's Christology:

> It is the nature of the person of Christ to be in the center, both spatially and temporally. The one who is present in word, sacrament and community is in the center of human existence, of history and of nature. It belongs to the structure of his person to be in the center. When we turn the question "Where?" back into the question "Who?" we get answer. Christ is the mediator as the one who exists *pro me*.[30]

For Bonhoeffer, Adam's fatal sin destroyed the immediacy of humanity's access at the transcendental boundary between Creator and creature. The cross of Christ absolves

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[29] Feil, *The Theology of Dietrich Bonhoeffer,* 59-81.

[30] Feil, *The Theology of Dietrich Bonhoeffer,* 75.

humanity's guilt making Christ and the cross the middle. In his work, *Creation and Fall* Bonhoeffer asserted, "The stem of the cross becomes the staff of life, and in the midst of the world life is set up anew upon the cursed ground. In the middle of the world the spring of life wells up on the wood of the cross."[31] Bonhoeffer placed great emphasis on the idea of God as the one who exists "pro me" in Christ which he later developed into the idea of "Christ the man for us." In short, the whole of Bonhoeffer's theological convictions and teachings rest on the incomprehensible, and extraordinary love of God for the "real world" expressed through the birth, life, suffering, death and resurrection of Jesus Christ.

Further, in his article, "For the Love of the World: Bonhoeffer's Resistance to Hitler and the Nazis," author Mark Brocker suggests that "the heart of Bonhoeffer's resistance was his confidence in God's deep love for the world. That deep love was the firm ground on which he took his stand in resisting Hitler and the Nazis".[32] In the book *Ethics* Bonhoeffer based his conviction on the argument that the central message of the New Testament is, "in Christ God has loved the world and reconciled it to himself." He referred to God's acceptance of the world as "a miracle of divine mercy."[33] For Bonhoeffer, God's love is not directed toward some ideal, romanticized, or over-spiritualized version of the world, but towards the "real world," the world as it actually

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[31] Dietrich Bonhoeffer, *Creation and Fall: A Theological Interpretation of Genesis 1-3*, ed. John C. Fletcher, trans. Editorial Staff of SCM (McMillan, NY: SCM Publishers, 1959), 93.

[32] Mark S. Brocker, "For the Love of the World: Bonhoeffer's Resistance to Hitler and Nazis," *Word and World* 38, no. 4 (Fall 2018): 366, accessed February 20, 2018, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=1&sid=b4be88c4-e2a3-4d34-88e52cae2f3bb3f8%40sessionmgr102&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=ATLAn4418644&db=reh.

[33] Dietrich Bonhoeffer, *Ethics*, ed. Victoria Barnett, trans. Reinhard Krauss and Charles C. West (Minneapolis, MN: Fortress Press, 2015), 66.

exits. Bonhoeffer explains it this way, "this love of God for the world does not withdraw from reality into noble souls detached from the world, but experiences and suffers the reality of the world at its worst."[34] Also in *Ethics,* Bonhoeffer introduces his concept of "genuine worldliness," a concept grounded in God's deep love for the world as revealed in, "the Crucified Reconciler," Jesus Christ. The cross symbolizes and reveals that the whole world has become godless by rejecting Jesus Christ. Yet, the cross also serves as the identifying mark of reconciliation for a sinful and lost world. Bonhoeffer writes, "the cross of reconciliation sets us free to live before God in a godless world, sets us free to live in genuine worldliness…[those who live genuine worldliness have]…the freedom and the courage to allow the world be the what it really is before God, namely, a world that in its godlessness is reconciled with God."[35]

In his *Letters and Papers from Prison* Bonhoeffer further distinguishes "genuine worldliness" from what he identified as "genuine religion." In genuine religion, the focus tends to shift away from the realities, struggles, and suffering in the real world to a fixation on the promises and outer boundaries of another, the heavenly realm beyond death. Another form of genuine religion is the tendency of some today to adopt a kind of supra-spirituality which tends to detach from concrete realities, particularly the sufferings of others, and align themselves with "otherworldly and/or utopianistic view of religion and church. This is similar to the focus of many of today's religions, particularly in charismatic and conservative evangelical churches where corporeal forms of suffering are often denied or ignored in search of other worldly blessings and benefits before or after

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[34] Bonhoeffer, *Ethics*, 83.

[35] Bonhoeffer, *Ethics*, 400-401.

death. This explains why hardly any American conservative evangelical churches are on the front lines of the many civil rights issues of our times. This was also Bonhoeffers criticism of both the Confessing and German Evangelical Churches. In response to genuine religion Bonhoeffer writes, "But it seem to me that this is just where the mistake and danger lie. Redemption now means redemption from cares, distress, fears, and longings, from sin and death, in a better world beyond the grave. But is this really the essential character of the proclamation of Christ in the gospels and by Paul? I should say not.[36]" Bonhoeffer argued that the difference between genuine religion and genuine worldliness is that the former is based on "mythological hope and the latter on "the Christian Hope of Resurrection."[37] A mythological truth is one that is meritless and baseless. It is not based on any substantive truth or history. It is based on a myth which reduces to nothing more than escapism. In contrasting the two he wrote:

> The Christian, unlike devotees to redemption myths, has no last line of escape available from earthly tasks and difficulties into the eternal, but like Christ himself ('My God, why hast thou forsaken me?'), he must drink the earthly cup to the dregs, and only in his doing so is the crucified and risen Lord with him, and he crucified and risen with Christ....Redemption myths arise from human boundary-experiences, but Christ takes hold a man at the center of his life.[38]

From this line of reasoning Bonhoeffer developed his ideas of "Religionless Christianity," "this Worldliness," and "Horizontal Transcendence," all of which center around an individual faith and obedience to Christ, the risen Savior. In other words, Bonhoeffer strongly believed that God's love for a fallen world was best manifested in

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[36] Dietrich Bonhoeffer, *Letters and Papers from Prison*, ed. Eberhard Bethge (New York, NY: MacMillan, 1972), 336.

[37] Bonhoeffer, *Letters and Papers,* 377.

[38] Bonhoeffer, *Letters and Papers,* 377.

the life, suffering, death and resurrection of Christ from the dead. Only through a personal conversion experience in and through Christ is true restoration with God possible. The only manifestation of that redemption is ones faithful obedience to God in the real world.

As God through Jesus is believed to be the God who is "for us" and "with us," so His followers, Christians, should also have that same love and intent towards a fallen world. In his *Cost of Discipleship* Bonhoeffer expounds on this employing the "Sermon on the Mount." Essentially, he lifts up the notion of Kenosis or "emptying oneself" to God on behalf of others. He suggests that in order for Christians to fulfill the purposes of God in their lives they should be filled with both the Word, and the Spirit, and learn to walk obediently with the Lord. This is much like the message of John the Baptist, "I must decrease that he might increase." In fact, Bonhoeffer believed that the disciple's call was a call unto death. He says that "when God calls a man, he bids him to come die.[39] By this he means that God has a specific plan and purpose for all believers. It is a call which requires complete submission to God through faith and obedience. It is a kind of abandonment of self for the Kingdom of God (Matt. 10: 37, 16:24-25, 1Pe 2:21). Thus, for Bonhoeffer responsible Christianity necessitates active engagement with the woundedness of a fallen world. This brings us to the third possible explanation of Pastor Bonhoeffer's radical engagement with Nazi resistance, his views on ecclesiology.

In his *Letters and Papers from Prison* Bonhoeffer wrote his famous "Outline for a Book" in which concerning the Church he writes, "The church is the church only when it

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[39] Dietrich Bonhoeffer, *The Cost of Discipleship*, 2nd ed., trans. R. H. Fuller, ed. Irmgard Booth (New York, NY: MacMillan, 1963), 87-89.

exists for others."[40] He believed that authenticity in the church's overall witness is based on true faith, community, sacrifice, service, teaching and being living examples of the love and grace of God towards others.[41] The church should approach life and ministry emulating Jesus' praxis of starting with a genuine and sincere "this-worldly' orientation; one that meets the world and people, not where they should be, but where they are.[42] It is a praxis that exemplifies God's undying and unconditional love for the world (John 3:16).

Bonhoeffer's view of the role and purpose of the church evolved through his earlier teachings and his spiritual journey. This point was expounded upon by author Patrick Franklin in his article, "Bonhoeffer's Missional Ecclesiology." Franklin reminds us that in his dissertation, the Communion of Saints, Bonhoeffer focused on a relational theological anthropology where the emphasis was on intrinsic social union between God and humanity. In Act and Being the emphasis is on God's freedom for others as expressed in His "binding and committing Himself to the Church community."[43] Franklin further asserts that in Creation and Fall Bonhoeffer interpreted the creation of beings the image of God in a relational sense meaning that humans were created being naturally free for God and others. However, as a result of the Fall, the human heart and volition became enslaved to flesh and sin.

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[40] Bonhoeffer, *Letters and Papers,* 282.

[41] Bonhoeffer, *Letters and Papers*, 83.

[42] Bonhoeffer, *Letters and Papers*, 369.

[43] Patrick Franklin, "Bonhoeffer's Missional Ecclesiology," *McMaster Journal of Theology and Ministry*, no. 9 (2007): 115, accessed December 15, 2018, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=5&sid=2a8873f3-b5e0-49e7-8478-6cd3feb302e7%40sessionmgr102.

Subsequently, Bonhoeffer described the human heart as a "*cor curvum in se.*" a heat turned in on itself. The resulting state was one of self-absorption, darkness, and sin. In response to this Franklin writes:

> Salvation, then, involves redeeming human beings from this self-absorbed state. It means awakening in believers' true freedom for God and Others. The Church which is the new humanity redeemed in Christ, is the community in which this other-centeredness is realized and practiced with the hope of finally being consummated at the *eschaton.*[44]

The evolution of Bonhoeffer's ecclesiology continues in the *Cost of Discipleship* where he focusses on the Christian (and thereby the Church's) "obligation" to participate in the sufferings of Christ in and for the world. This is what he means by, "following the way of the Cross." In life together, Bonhoeffer teaches that once someone actually experiences the grace and mercy of God, they will be inspired to serve rather than judging others. Thus, it is apparent that throughout Bonhoeffer's brief career his understanding of the Church and Christian responsibility were ever evolving. In essence, Bonhoeffer was convinced that the Church's primary purpose was to point people to the invisible God who's always in our midst and who is always "for us" in and through the God-man, Jesus Christ, even at great personal cost, including death. In fact, Bonhoeffer identified what he saw as "Four Stations on the Path to Freedom which every believer must traverse: discipline, action, suffering and death."[45] Like Fr. DeVeuster, Bonhoeffer's convictions eventually led him to pay the ultimate price.

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[44] Franklin, "Bonhoeffer's Missional Ecclesiology," 115, accessed December 15, 2018, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=5&sid=2a8873f3-b5e0-49e7-8478-6cd3feb302e7%40sessionmgr102.

[45] Bonhoeffer, *Letters and Papers*, 370-371.

Dietrich Bonhoeffer and Father Damien Deveuster were different in as many ways as the similarities they shared. Unlike Fr. Damien, Bonhoeffer was a very astute and disciplined scholar who pursued his theological studies to the Ph.D. level earning his doctorate at only twenty-one-years of age. Fr. Damien's mission and ministry were very singular in focus, whereas Bonhoeffer's curiosity's and interests led him to the travel and study abroad and the get involved with international initiatives like the World Council of Churches. He even planned to travel to go to India to study Mohandas Gandhi's non-violent resistance to British rule hoping to apply to same to the resistance of Nazism. Bonhoeffer was not just a scholar, he was a theologian, a professor and a pastor. Nonetheless, the two men have some very significant similarities. For example, they were both raised in well-established European homes by respectable parents. They both received a call into ministry at relatively young ages. Both Damien and Dietrich's fathers were initially opposed to their interest in ministry, wanting them to follow them in their respective fields instead. Both men left home early in life to pursue theological studies. Both men lived and ministered in oppressive social, political, and economic circumstances. Both exhibited a great deal of concern for the well-being of others and acted on these concerns in such a way that it led to them both making the "ultimate sacrifice" in service to others. John 15:13 reads "greater love has no one than is: to lay down one's life for his friends." However, the question remains, what is compassion and do Bonhoeffer's (and de Veuster's) actions constitute true compassionate care?

Compassion is a compound word comprised of the Latin root "passio," meaning "to suffer, and the prefix "com" which means "together.[46] Thus the word compassion

[46] Merriam Webster, "Compassion," last modified March 22, 2019, accessed March 25, 2019, https://www.merriam-webster.com/dictionary/compassion.

literally means "to suffer together." Researchers agree that it is the feeling that arises when one is confronted with another's suffering and feels motivated or inspired to take actions to relieve that suffering. Psychologist Dacher Keltner, of the University of California, Berkeley observes that as a concept compassion is often identified as synonymous to empathy or altruism.[47] While these concepts are related, they are not the same. Empathy refers more generally to our ability to take the perspective of and or feel the emotions of another person. Compassion refers to the mediating or helpful actions that occur as a result of empathetic feelings. Kelther writes, "Altruism, in turn, is the kind, selfless behavior often prompted by feelings of compassion, though one can feel compassion without acting on it, and altruism isn't always motivated by compassion."[48] Similar distinctions between compassion, empathy and altruism were made by Dr. Emma Seppala of Stanford University's Center for Compassion and Altruism Research and Education. She Wrote:

> What is compassion and how is it different from empathy or altruism? The definition of compassion is often confused with that of empathy. Empathy, as defined by researchers, is the visceral or emotional experience of another person's feelings. It is, in a sense, an automatic mirroring of another's emotion, like tearing up at a friend's sadness. Altruism is an action that benefits someone else. It may or may not be accompanied by compassion…Although these terms are related to compassion, they are not the identical. Compassion often does, of course, involve an empathic response and an altruistic behavior. However, compassion is defined as the emotional response when perceiving suffering and involves an authentic desire to help.[49]

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[47] Dacher Keltner, "Compassion Define," The Greater Good Science Center, accessed March 25, 2019, https://greatergood.berkeley.edu/topic/compassion /definition.

[48] Keltner, "Compassion Define," accessed March 25, 2019, https://greatergood.berkeley.edu/topic/compassion /definition.

[49] Emma Seppala, "The Compassionate Mind," Association for Psychological Science, *Observer* (May/June 2013): 2, accessed March 22, 2019, https://www.psychologicalscience.org/observer/the-compassionate-mind.

Moreover, Dr. Hooria Jazaieri, also of Stanford University and her colleagues found the concept of compassion to be a "multi-dimensional process" comprised of four key components. First, there is a cognitive empathic awareness of suffering. Examples of this included witnessing or being made aware of starving, abused children, seeing someone stranded along the side of the road, and or abandoned animals. The second component of compassion is affective in nature. It involves a sympathetic or some other emotional response to the suffering. Third there is a manifest presence of intentionality in one's desire to see relief to suffering. The fourth component of compassion is being motivated into action. It is a preparedness and willingness to help end the perceived suffering.[50] In summary, authentic compassion seems to involve a willingness to take selfless actions on behalf of others to alleviate suffering.

In the case of Father Damien DeVeuster, he petitioned the Catholic Church for permission to take his brother Pamphile's place as a missionary to Hawaii. Little is known about his knowledge or interest in the plight of lepers there prior to his arrival. However, once there it did not take him long to become versed in the island's ethos, its religious, social, political and economic tensions and disparities (stage 1 – Cognitive/Empathic Awareness). He took notice of the discriminatory practices of the empowered businessmen and Protestant missionaries towards natives, especially lepers (Sympathetic Concern). Then when the dangerous and very risky opportunity for permanent habitation and ministry among the lepers of Molokai presented itself, Damien

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[50] Hooria Jazaieri et al., "A Randomized Controlled Trial of Compassion Cultivation Training: Effects on Mindfulness, Affect, and Emotion Regulation," *Motivation and Emotion* 38, no. 1 (February 2014): 23, accessed March 23, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=5&sid=5051a154-f2ff-44c4-8edb-4407dc7f26a5%40sdc-v-sessmgr06.

did not hesitate to volunteer for the assignment (Intention). Finally, once on the island with the lepers, he took an "all-in," "no bars held" approach to helping to relieve the suffering conditions of the lepers. He identified with the lepers and committed the rest of his albeit short life living as a servant among them.

Similarly, from his early youth Dietrich Bonhoeffer told his dad that he not only wanted to pursue a career in ministry, he wanted to "reform the church." That is exactly what he sat out to do as a young academician and professor of theology. Even his post doctorate studies and travels had to do with learning and expanding his understanding of God's presence and ministry via Jesus Christ in the world. However, after Hitler's rise to power Bonhoeffer became more conscientious about the suffering visited upon Jews and other non-Aryan people by the Nazi (Cognitive/Empathic Awareness) and he was moved with sympathy (Affective Component). He immediately started teaching and preaching against Christian capitulation to the state (Intentional Component). To the chagrin and dismay of friends, colleagues, and critics alike, especially those in the German Evangelical and Confessing Churches, Bonhoeffer eventually "jumped all in" with the resistance movement. Like DeVeuster his actions would lead not only to questionable political extremes, but to an untimely death at the young age of thirty-nine. Based on the biblical and clinical evidence above neither Deveuster's nor Bonhoeffer's motives can be questioned. These were in fact, men of incredible faith and conviction who embodied the very ethic implied in Jesus' command to "love your brother as you love yourself, (Mat. 22:39)." Theirs was a genuine kind of compassion that this "world come of age" desperately needs.

Nonetheless, while one cannot question the motives of their hearts, one can inquire into what message, what witness and meaning their lives and sacrifices offer us today. *In the Cost of Discipleship,* Bonhoeffer again emphasized the importance of Christian faith and obedience to the presence and call of God on their lives in and through the person Jesus Christ. Thus, to grow in Christ means to die to self and one's own agenda and engage spiritual growth, guidance and formation through Christ. Thus he asserts, when, "God calls a man he bids him to come die." Bonhoeffer further believes that this call extends to all Christians and so does obligatory faith and obedience. However, he believes that a very small percentage of believers are actually called to martyrdom. He included himself in that number. I believe that the list could also include people like Fr. Damien, and Martin Luther King, Jr. However, the vast majority of believers are not called to martyrdom. What about them? While they are doing all this caring for others amidst the ever-present chaos in the cosmos, all the pain, hurt, and suffering in the real world, how are their personal human needs being addressed? This question is never taken up in the lives of Fr. Damien and Dietrich Bonhoeffer. For them, compassionate care was basically one directional, from them to others. These questions are even more significant in today's multi-religious, multi-faceted and increasingly secularized world; a world in which, while the face of Christianity seems to be ever-evolving, the need for compassion and compassionate care is as urgent as ever.

Compassionate care is the focus of this Doctor of Ministry Project. The focus will primarily be on the emotional needs of caregivers themselves. Interestingly, this is something that was completely absent in the lives of both de Veuster and Bonhoeffer. The context for this project is a hospice company wherein most of the employees profess

feeling a sense of "calling" to this field. Like de Veuster and Bonhoeffer they work very closely and intimately with patients and families living daily under the constant and dreadful threat of death. It is a field that demands a great deal of compassion, humility, patience, and selfless service to others. Many people employed therein profess a sense of spirituality, and some do not. Recent trends in the field affecting employee morale, productivity, and retention involves what some clinicians call compassion fatigue or caregiver burnout. These are caused by the overwhelming sense of stress and pressures brought about by the nature of the work itself. It should be noted however, that caregivers apply not only to hospice employees (though they are the targeted audience for this project), and it also applies to anyone intricately involved with terminally ill patient: family members, friends, clergy and community members. Kelter believes that these internalized stresses leading to burnout are due to the care givers failure to exercise what he calls "self-compassion."[51] This seems to be consistent with Jesus' teaching about "loving others as we love ourselves." When individuals are in a position, emotional and spiritual health and wellness, they are more prepared and equipped to help others.

[51] Keltner, "Compassion Define," accessed March 25, 2019, https://greatergood.berkeley.edu/topic/compassion /definition.

CHAPTER FIVE

INTERDISCIPLINARY FOUNDATIONS

The purpose of this chapter is to gain more insight from the field of psychology into the nature and possible remedies of compassion fatigue. The chapter begins with a literature review of the research on compassion, stress, and compassion fatigue as differentiated from burnout. This is followed by a review the history of compassion as a response to human suffering including those suffering abandonment related issues. The focus will primarily be on lessons learned from those studied to date through this project: Fr. Damien de Veuster (Historical Chapter), Dietrich Bonhoeffer (Theological Chapter) and the Lord Jesus Christ (Biblical Foundation Chapter). Next, I'll introduce the scales and tools used to measure compassion fatigue. This chapter concludes with a discussion of how I intend to apply these finding to this doctoral project giving particular attention to two prominent tools used to assess and measure compassion fatigue.

From the beginning of the doctoral journey at United, one of the guiding interests has been looking into the nature of human suffering. It is interesting to know how do hurting people find healing and wholeness? The special topic of research involves those struggling with issues related to abandonment. According the *Cambridge Dictionary*, abandonment is, "the act of leaving someone or something or of ending or stopping

something, usually forever."[1] Abandonment often leaves a lifetime of emotional, spiritual and social challenges for its victims. Author Ann Pietrianelo, writes, "Anyone can develop a fear of abandonment. It can be rooted in a traumatic experience you had as a child or as a distressing relationship in adulthood.[2]" Abandonment has been likened to adulthood disorders like low self-esteem, avoidant personality and borderline personality disorder. In fact, it is very common for adult survivors of some form childhood abandonment to experience long term effects such as: trust issues, anger issues, mood swings, codependency, fear of intimacy, anxiety disorders, panic disorders, and depression.

From my own life's struggles I am all too familiar with the issue of abandonment. It may be recalled from the Spiritual Biography that the author's mother was gravely injured during his birthing process and died six months later. This initiated a life-long journey of painful and traumatic experiences, often at the hands of those adults who should have been nurturers and protectors. This kind of victimization resulted in a life-long struggle with issues like self-worth, trust, and human connectedness, especially with males, and a strong desire to heal and to help others suffering with abandonment related issues heal as well. Moreover, the context for this doctoral project is hospice because I have been employed as a Chaplain or Bereavement Services Manager in this field for the past eighteen years.

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[1] Cambridge Online Dictionary, "Abandonment," accessed March 30, 2019, https://dictionary.cambridge.org/us/.

[2] Ann Pietrangelo and Timothy J. Legg, "What Is Fear of Abandonment, and Can It Be Treated?" Healthline Newsletter, February 13, 2019, 1, accessed March 30, 2019, https://www.healthline.com/health/fear-of-abandonment.

Many of those who work in hospice find it both rewarding and challenging. Hospice Care Professional (HPCs) encounter potentially stressful circumstances as they interact with their patients and families. In the current context, over 90% of the employees are field based worker who spend every day helping vulnerable patients and families navigate their way through the complexities of sickness, suffering, and death in their own homes, or places they call home (nursing homes and hospitals). Many perceive hospice work as a sense calling from which they derive a great deal of satisfaction. Others see it as simply their job. It is how they make a living. Providing comfort and support to patients and families are what they are expected to do. It is their duty. Like many people who put in an honest day's work for an honest day's pay, it is what is expected of them. Nothing more, nothing less. From an uninformed or 'outsider's perspective this seems all too reasonable, but there more to it, much more.

Vitas Healthcare is a hospice care provider. Studies have shown that the inherent stress of working in healthcare can have traumatic effects on healthcare professionals' sense of well-being. This is even more evident with palliative medicine where nearly every case results in death. As discussed in the previous chapter this alone makes hospice a very emotionally, physically, and spiritual exasperating field. Unfortunately, many companies in the healthcare industry are so profit and results driven that all too often minimal resources and or efforts are allocated toward employee support initiatives. In my opinion, this constitutes a kind of institutional abandonment leaving employees subject to a very common phenomenon in healthcare called compassion fatigue and or caregiver burnout. Authors Dr. John Ludgate and Martha Teater make this point in their book, "Overcoming compassion fatigue: A Practical Resilience Workbook." They write,

"The prevalence of caregiver stress and/or burnout is high among helping professionals. Some 79% of hospice nurses have moderate to high compassion fatigue.[3]" Thus, these phenomena seem to the be natural result of one's own emotional and spiritual needs remaining unmet while constantly being expected to be a source of comfort and reassurance to others. With time, even the sincerest people can be subject to depletion.

Literature Review: Compassion

Compassion as defined in the historical chapter is the ability to empathize with the suffering of others accompanied by a strong sense to do something to bring relief. Compassion is not only normative in human relations; it is a vital determinant of the nature and quality of those relationships. It is often used interchangeably with words like empathy or altruism, but this is an inaccurate understanding of compassion. Empathy is defined by researchers as the visceral or emotional experience of another's feelings. Altruism involves an action taken to benefit someone else. It may or may not contain empathy or compassion. Compassion, however, always involves both empathy and a sense of altruism with an authentic desire to help.[4] The Association for Psychological Science (APS) Psychologist and Stanford Professor, Dr. Emma Seppala argues that compassion is an intrinsic human instinct pertinent to the evolution and survival of the

[3] Martha Teater and John Ludgate, *Overcoming Compassion Fatigue: A Practical Resilience Workbook* (Eau Claire, WI: PESI Publishing and Media, 2014), 13.

[4] Emma Seppala, "The Compassionate Mind," Association for Psychological Science," *Observer*, (May/June 2013): 2, accessed March 22, 2019, https://www.psychologicalscience.org/observer/the-compassionate-mind.

human species. She based this argument on the works of fellow APS researchers like Jean Decety of the University of Chicago,[5] Michael Tomasello at Germany's Max Planck Institute,[6] and Harvard University's David Rand.[7] All of whom conducted studies into the notion of compassion as an intrinsic instinct using either laboratory rats, chimpanzees, human infants and or human adults as their subjects. All of them yielded positive or affirmative results concerning the inherently innate nature and relevance of compassion to animals and humans alike. One study even suggests that kindness is one of the most highly valued characteristics both men and women seek when looking for a romantic partner.

Further, Seppala argues that showing compassion has physical and psychological benefits as well. Citing studies by APS researchers Ed Diener and Martin Seligman, a pioneer of the psychology of happiness and human flourishing, Seppala suggests that maintaining a positive and compassionate state of mind promotes physical wellness.[8]

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[5] Inbal Ben-Ami Bartal, Jean Decety, and Peggy Mason, "Empathy and Pro-Social Behavior in Rats," *Science* 334, no. 6061 (December 9, 2011): 1427, accessed April 30, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=5&sid=56bc76dd-15be-443d-ba40-39551dcedbc9%40sessionmgr4010&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsgcl.275850377&db=edsgov.

[6] Michael Tomasello, Malinda Carpenter, and Peter R. Hobson, *The Emergence of Social Cognition in Three Young Chimpanzees* (Boston, MA: Blackwell Publishing, 2005).

[7] Collin M. McCabe and David G. Rand, "Coordinated Punishment Does Not Proliferate When Defectors Can Also Punish Cooperators," *Journal of Communication Research* 6, no. 4 (2014): 335-348, accessed March 22, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=13&sid=56bc76dd-15be-443d-ba40-39551dcedbc9%40sessionmgr4010&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=101835049&db=ufh.

[8] Rosemarie Kobau et al., "Mental Health Promotion in Public Health: Perspectives and Strategies from Positive Psychology," *American Journal of Public Health* 101, no. 8 (August 1, 2011): e2, accessed May 1, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=17&sid=37be8e57-a092-4071-91e7-638de2aee92c%40sessionmgr102.

She writes "connecting with others in a meaningful way helps us enjoy better mental and physical health and speeds up the recovery from disease."[9] It may even lengthen the span of one's life. Psychologically, compassion affects our sense of well-being because it gives pleasure. This is because "pleasure centers" in the brain normally active during pleasurable events like eating dessert, receiving money, or having sex, are equally as active when compassion in being offered. For example, researchers found that giving money is as pleasurable and gratifying as receiving money in test subjects.[10] Referencing a study presented at Stanford Medical School's Center for Compassion and Altruism Research and Education (CCARE) by APS Fellows Dr. Steve Cole and Dr. Barbara Fredickson.[11] Seppala writes:

> Their study evaluated the levels of cellular inflammation in people who describe themselves as "very happy." Inflammation is at the root of cancer and other diseases and is generally high in people who live under a lot of stress. We might expect that inflammation would be lower for people with higher levels of happiness. Cole and Fredrickson found that was only the case for certain "very happy" people. They found that people who were happy because they lived the "good life" (sometimes also known as "hedonic happiness) had higher levels of inflammation, but, on the other hand, people who were happy because they lived a life of purpose or meaning (sometimes also known as "eudaimonic happiness") had low inflammation levels. A life of meaning and purpose is one focused less on satisfying oneself and more on others. It is a life rich in compassion and greater meaning.

In summary, Seppala argues that compassion is a vital part of human life and well-being. It has both physical and psychological benefits. It can also broaden our prospective and

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[9] Seppala, "The Compassionate Mind," 5, accessed March 22, 2019, https://www.psychologicalscience.org/observer/the-compassionate-mind.

[10] Seppala, "The Compassionate Mind," 3, accessed March 22, 2019, https://www.psychologicalscience.org/observer/the-compassionate-mind.

[11] Barbara Fredrickson et al., "Psychological Well-Being and the Human Conserved Transcriptional Response to Adversity," *PLoS ONE* 10, no. 3 (March 2015): 1-17, accessed May 1, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=33&sid=37be8e57-a092-4071-91e7-638de2aee92c%40sessionmgr102.

increase our overall sense of connectedness to others. In fact, Seppala believes that if more people could learn to be more in touch with their natural compassionate instincts the world would be a better place.

The ability to effectively emote authentic empathy and compassion are also important aspects of hospice work. However, rewarding, hospice work can also be very challenging for individuals because of the inherent stressors that tend to accompany it. Hospice frontline workers (i.e. Physicians, Nurses, CNAs, Chaplains, Social Workers, and others) are constantly exposed to the social, emotional, economic, psychological, and spiritual complexities of terminal illness and death. In their article, "A Study of the Relationship between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout Among Hospice Professionals," authors Karen Davies, Jeremy Linton, and Randall Davies agree that "stress is inherent in the helping professions."[12] Stress can be defined as a dynamic interaction between persons and their environments in which assigned tasks or situations are perceived as taxing exceeding the person's skills or abilities, or jeopardizing his or her well-being.[13] The cumulative effects of stress can have physical, mental, and emotional impacts on individuals in the helping field. Psychologist Suzanne Slocum-Gori of the University of British Columbia's School of Population and Public Health (et. al), in their article, "Understanding Compassion Satisfaction, Compassion Fatigue, and Burnout: A Survey of the Hospice and Palliative Care Workforce," suggest that very nature of hospice work itself makes workers

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[12] Karen Alkema, Jeremy M. Linton, and Randall Davies, "A Study of the Relationship between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout Among Hospice Professionals," *Journal of Social Work in End-of-Life and Palliative Care* 4, no. 2 (February 2008): 102, accessed March 29, 2019, http://www.hawortpress.com.

[13] Richard S. Lazarus and Susan Folkman, *Stress, Appraisal, and Coping* (New York, NY: Springer Publishing Company, 1984), 201.

vulnerable to stress. They write, "HPC [hospice and palliative care] workers empathize with the losses their patients are experiencing in the dying process and often feel a sense of personal failure that they cannot help their patients; working on the edge between 'life' and 'death' cultivates an acute awareness of the fragility of life."[14] The stressors related to hospice work include but is not limited to death and dying, grieving families, personal grief, traumatic stories, observing extreme physical pain and suffering, strong emotional states like anger and depression, and emotional physical exhaustion.[15] Physician, Dr. Rachel N. Remen in her book "Kitchen Table Wisdom" wrote, "The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water and not get wet.[16]" In fact, I personally know of one example where a hospice nurse was facing her own health concerns, had financial and domestic problems at home, disagreements with physicians and administration over patient treatment objectives, and was still expected to be a source of compassionate support for her patients daily, rain, snow, or sunshine. One can only wonder how long a person keep going under this type of duress. Studies have shown that compassionate care coupled with constant distress over time can lead to burnout and or compassion fatigue.

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[14] Suzanne Slocum-Gori et al., "Understanding Compassion Satisfaction, Compassion Fatigue, and Burnout: A Survey of the Hospice and Palliative Care Workforce," *Palliative Medicine* 27, no. 2 (February 2013): 172-173, accessed April 23, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=1&sid=3e322de3-38ba-49b8-aab6-2a1cb26cc813%40sessionmgr120&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=2013-04001-010&db=psyh.

[15] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 102, accessed March 29, 2019, http://www.hawortpress.com.

[16] Rachel Naomi Remen, *Kitchen Table Wisdom: Stories That Heal* (New York, NY: Riverhead Books, 2006), 52.

Historically, the term burnout has been used to describe the phenomenon in which physicians and nurses detach themselves from patients and families, particularly those who were dying.[17] This tendency has been linked to a preponderance of stress in the treatment of patients with terminal illness. Dr. Brenda Sabo of the Dalhousie University's School of Nursing defines burnout in her article, "Adverse Psychosocial Consequences: Compassion Fatigue, Burnout and Vicarious Traumatization: Are Nurses Who Provide Palliative and Hematological Cancer Care Vulnerable?" She writes, "It [burnout] is most commonly defined as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur in individuals who do "people work." Initially conceptualized to directly reflect the effects of "people work," burnout has been expanded to include all occupational groups."[18] Subsequently, burnout can affect one's perceptions, attitude and overall professional comportment in the workplace. Researcher Dr. Gladys Catkins Keidel, in her article, "Burnout and Compassion Fatigue among hospice caregivers," make this point noting that burnout may lead to negative self-concept, negative attitudes about work, and loss of caring about work related issues including patients.[19] Some of the causes of burnout among hospice

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[17] Nancy Arcock and Deborah Boyle, "Interventions to Manage Compassion Fatigue in Oncology Nursing," *Clinical Journal of Oncology Nursing* 13, no. 2 (April 2009): 184, accessed April 23, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=4&sid=3e322de3-38ba-49b8-aab6-2a1cb26cc813%40sessionmgr120.

[18] Brenda M. Sabo, "Adverse Psychosocial Consequences: Compassion Fatigue, Burnout and Vicarious Traumatization: Are Nurses Who Provide Palliative and Hematological Cancer Care Vulnerable?" *Indian Journal of Palliative Care* 14, no. 1 (June 2008): 25, accessed April 29, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=6&sid=db72fbe3-03ad-411e-8d01-cabc03bc127e%40sessionmgr4006.

[19] Gladys Catkins Keidel, "Burnout and Compassion Fatigue Among Hospice Caregivers," *American Journal of Hospice and Palliative Medicine* 19, no. 3 (May 1, 2002): 200-205, accessed May 1, 2019, https://journals-sagepubcom.ezproxy.uakron.edu:2443/action/doSearch?field1=AllField&text1=10499091&volume=19&page=200.

workers are believed to be low salaries, demanding schedules, varying work shifts, low social recognition, lack of financial resources, role ambiguity, and difficult client behaviors.[20] Burnout is believed to have a prolonged and slow onset, and may result in employees having to leave their jobs.[21]

Compassion fatigue, a construct similar to that of burnout is defined as "a deep physical, emotional and spiritual exhaustion accompanied by acute emotional pain.[22] It is believed to be the result of long-term effect of displays of compassion in the presence of suffering. It is the result of long-term exposure to human suffering. It can be seen as the cumulative effect of listening to traumatic stories, seeing agony and despair up close and personally, while receiving minimal, if any, emotional support in the workplace coupled with absent or insufficient self-care strategies. Slocum-Gori (et all) describe compassion fatigue as "a response that emerges suddenly and without warning and includes a sense of helplessness, isolation, and confusion.[23] Its symptoms include difficulty sleeping, increased startled response, avoidance, obtrusive thoughts about the events, and depressed or anxious moods.[24] In fact, the emotional weight of compassion fatigue has

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[20] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 103, accessed March 29, 2019, http://www.hawortpress.com.

[21] Arcock and Boyle, "Interventions to Manage Compassion Fatigue in Oncology Nursing," 184, accessed April 23, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=4&sid=3e322de3-38ba-49b8-aab6-2a1cb26cc813%40sessionmgr120.

[22] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 103, accessed March 29, 2019, http://www.hawortpress.com.

[23] Slocum-Gori et al., "Understanding Compassion Satisfaction," 173, accessed April 23, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=1&sid=3e322de3-38ba-49b8-aab6-2a1cb26cc813%40sessionmgr120&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=2013-04001-010&db=psyh.

[24] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 103, accessed March 29, 2019, http://www.hawortpress.com.

often been referred to as the "cost of caring." Alkema (et al) also assert that because workers spend their work days directly involved with the dynamics of suffering, dying and death, they are at a greater risk than others in the helping profession for compassion fatigue, which can ultimately impact the quality of service that they are able to offer patients.[25] In fact compassion fatigue specialist and author Francoise Mathieu in her book, "The Compassion Fatigue Workbook," suggests that if left undiagnosed and treated burnout and compassion fatigue could potentially lead to PTSD or worse. She writes, "Ironically, helpers who are burned out, worn down, fatigued, and traumatized tend to work harder. As a result, they go further and further down a path that can lead to a serious physical and mental health difficulties, anxiety, substance abuse, chronic pain, other stress-related illnesses, and even suicide.[26]" Thus, increased education and awareness into these "occupational hazards" for hospice workers are of paramount importance.

As shown in the introduction compassion fatigue, psychologists Marné Ludick and Charles Figley outlined nine theoretical factors that are instrumental in identifying and addressing the issue compassion fatigue which they refer to as secondary traumatic stress (STS). Accordingly, long term and constant expose to suffering has erosive effects on the caregiver's emotional and physical well-being. Ludwich and Figley suggest that "exposure to suffering is the first pathway to STS by which workers assume client

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[25] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 103-104, accessed March 29, 2019, http://www.hawortpress.com.

[26] Francoise Mathieu, *The Compassion Fatigue Workbook: Creative Tools for Transforming Compassion Fatigue and Vicarious Traumatization* (New York, NY: Routledge, Taylor and Francis Group, 2012), 8-9.

suffering and internalize some of the expressed energy from each encounter."[27] They further argue that:

> When providing an empathic response, the worker is projected into the distressed client's position, experiencing their fear or suffering. Over time, constant empathic responses can have a numbing effect and elicit STS (Salston & Figley, 2003). During an empathic response, professionals draw heavily upon their skills, training and talent to provide the best service (Figley, 2002a). As stated before, those without empathy training are at an especial disadvantage as they have fewer inner resources to draw from. And, when one's efficiency and resources are overwhelmed, one's health and wellbeing is jeopardized (Craig & Sprang, 2010).[28]

They too refer to this phenomenon has the "cost of caring." This finding was also supported Slocum-Gori (et. al). They argue that hospice workers' "constant exposure to death, inadequate time with patients, growing workloads, inadequate coping with their own emotional response to the dying, increasing numbers of death, communication difficulties with dying patients and families and feelings of grief, and guilt, if untreated can lead to depression and physical illness."[29] Thus empathy and compassion are vitally important to human well-being, but extensive exposure to suffering without occupational supports, or a vibrant support system outside of work to add balance, those working in the helps industry are vulnerable.

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[27] Ludick and Figley, "Toward a Mechanism for Secondary Trauma Induction and Reduction," 113, accessed March 2, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=4&sid=dd36d761-bcdd-471d-acdc-198b3c2ec4a1%40sdc-v-sessmgr04&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsovi.10.1037.trm0000096&db=edsovi.

[28] Ludick and Figley, "Toward a Mechanism for Secondary Trauma Induction and Reduction," 113, accessed March 2, 2019, http://eds.a.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=4&sid=dd36d761-bcdd-471d-acdc-198b3c2ec4a1%40sdc-v-sessmgr04&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=edsovi.10.1037.trm0000096&db=edsovi.

[29] Slocum-Gori et al., "Understanding Compassion Satisfaction," 173, accessed April 23, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/detail/detail?vid=1&sid=3e322de3-38ba-49b8-aab6-2a1cb26cc813%40sessionmgr120&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=2013-04001-010&db=psyh.

Further, before leaving this part of the chapter, it is important to distinguish burnout from compassion fatigue. Mathieu defines burnout as a "…term that has been used widely to describe the physical and emotional exhaustion that workers can experience when they have low job satisfaction and feel powerless and overwhelmed at work.[30]" It is often accompanied by feelings of hopelessness, work-related problems, lack of support in the workplace, and a questioning of the efficacy of one's efforts. It has a slow onset and is primarily the result of long-term work-related issues. Compassion fatigue on the other hand, is the result of secondary exposure to traumatic events. Its symptoms can have a rapid onset and may be related to one particular event or to prolonged exposure to traumatic stories. Concerning her own experience with compassion fatigue clinician Laura van Dernoot Lipsky was very transparent. She writes, "I finally came to understand that my exposure to other people's trauma had changed me on a fundamental level. There had been an osmosis. I had absorbed and accumulated trauma to the point that it had become part of me, and my view of the world had changed.[31]" Burnout can affect anyone in any field, but compassion fatigue primarily affects those who help others.[32] Therefore, for the purposes of this doctoral project, the focus will be specifically on compassion fatigue.

However, not all hospice workers wrestle with compassion fatigue. Alkema (et al) write, "Long term displays compassion, do not always lead to negative emotional states such as burnout and Compassion Fatigue; a sense of compassion satisfaction can

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[30] Mathieu, *The Compassion Fatigue Workbook*, 10.

[31] Laura van Dernoot Lipsky, *Trauma Stewartship* (Emeryville, CA: Althea Press, 2018), 3.

[32] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 101, accessed March 29, 2019, http://www.hawortpress.com.

result."[33] Compassion satisfaction has been defined as the "pleasure derived from being able to do your work well."[34] It is believed to be related to those experiences when Hospice Care Professionals are able to see patients improve or change for the better as a result of his or her efforts. In a reciprocal kind of way, it inspires and encourages the HPC. Factors that enhance compassion satisfaction are having a positive effect, being optimistic, having and utilizing several social resources, maintaining good health and balanced living. In fact, many believe that compassion satisfaction is itself a remedy to compassion fatigue.

For the purposes of this project it is important to consider the significance of compassion satisfaction and compassion fatigue in the lives of Fr. Damien de Veuster and Dr. Dietrich Bonhoeffer. It is also important to look to Jesus on the cross as example of compassion satisfaction. No one, in my opinion, can question the authenticity of Fr. De Veuster's empathy or compassion. His biographer, John Farrow in his book, *Damien the Leper: A life of Magnificent Courage, Devotion, and Spirit* recounts that even as a youth Damien had a "self-sacrificing nature;" one that always went out of his way to help those in need.[35] It is as if empathy and compassion were programmed into his DNA (as Dr. Seppala would suggest). Then right out of seminary at the young age of only twenty-three, he petitions his superiors for a mission assignment to the Hawaii Islands, one that he knew meant he'd never see his family again. After serving an island church for nine

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[33] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 104, accessed March 29, 2019, http://www.hawortpress.com.

[34] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 104, accessed March 29, 2019, http://www.hawortpress.com.

[35] John Farrow, *Damien the Leper: A Life of Magnificent Courage, Devotion and Spirit* (New York, NY: Double Day Dell, Inc., 1954), 21.

years, he readily volunteered to be banished to the "leper colony" at Molokai at the age of thirty-three knowing again that he would die there. While some may call this an uncommon kind of valor, others see it as an extraordinary kind of love (agape like in nature). Call it what you will, it was certainly a tremendous display of empathy and compassion. If the theorists above are correct, it may also have been the very thing that made him vulnerable.

It should be remembered at the time of his banishment, Kalaupapa at Molokai was in a desperate state. This was due to the inhumane practices of compulsory segregation, governmental neglect, poor housing, insufficient food supplies, inadequate medical care, and a severely progressive terminal illness. Author, Kerri A. Inglis, in her article "One's Molokai Can Be Anywhere: Global Influence in the Twentieth Century History of Hansen's Disease," employed some ominous phrases when describing conditions there. Accordingly, Kalaupapa was considered a "hell on earth;" an island so deplorable that it was surnamed the "natural prison," or "the grave where one is buried alive.[36] Further, Farrow described Damien's first few moments with the people of Molokai this way:

> It was hard to feel any kinship with the live things that surrounded him. They were without faces or if they had faces they were distorted beyond resemblance to any human shape. Where eyes has been there were craters of pus; and there were gaping cavities, disease infected holes that merged with rotting mouths, where noses should be. Ears were pendulous masses many times their natural size, or were shriveled to almost nothing. Hands were without fingers and some and some arms were merely stumps. Feet and legs were equally repulsive and the bodies of most of them were bloated and pitted, shrunken and swollen, but never of a normal shape. They were a pitiable, revolting sight; their wounds and sores being undressed or covered with filthy matter-soaked rags.[37]

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[36] Kerri A. Inglis, "One's Molokai Can Be Anywhere: Global Influence in the Twentieth Century History of Hansen's Disease, *Journal of World History* 25, no. 4 (2014): 611-627, accessed July 16, 2018, https://www.jstor.org/stable/43818467.

[37] Farrow, *Damien the Leper,* 195.

From the very start Fr. De Veuster identified with the lepers with a compassion filled heart. This point was highlighted by John Milsome in his book, *Damien: Father to the Lepers*. He writes: "Damien identified himself with these poor lepers. He was their champion: he fought ceaselessly for their rights. He was a father and friend: he was totally available to help them in all their needs, from lifting broken spirits to bandaging leprous sores, from organizing musical and sporting events to making coffins and digging graves."[38] He even addressed them as, "We lepers" long before contracting the illness himself.[39]

While the terms burnout and compassion fatigue was not yet discovered during his lifetime it is not inconceivable that he was a great candidate for the illness. He was isolated and constantly exposed to tragedy and death, overworked with little-to-absolutely no outlet or supports. It is reasonable to assume that he was under a great deal of physical stress, emotional strain, social challenges, and spiritual isolation. Farrow reports what Fr. Damien longed for the most were collegiality, friendship, and someone to hear his confessions. This is because of the segregation laws concerning lepers which prohibited constant contact with the outside world. In fact, he was so desperate for this that he even resorted to saying his penitence from a smaller boat to a priest on a steamer because as a leper he could not board the steamer. He so immersed himself in helping others he neglected his own wellbeing. These are classic indicators of someone vulnerable to compassion fatigue and burnout.

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[38] John Milsome, *Damien: Father to the Lepers* (Ann Arbor, MI: Servant Publication, 1989), add page number.

[39] Milsome, *Damien,* 34.

Similar observations can be made about the life and ministry of Dietrich Bonhoeffer. For example, what prompted him to leave his home in Germany and take his first post in ministry in Spain? Then travel to the United States to study for a couple of years with plans of traveling to India to study under Ghandi. Whatever he was searching for, he certainly did not find it at home. He was embroiled with the social and political tensions with the Nazi regime. Bonhoeffer was heartbroken and disillusioned by the acquiescence of the German Christian and Confessing Churches over their failure to exemplify what he saw as true, self-sacrificing Christian love. He saw this as a kind of abandonment of the true church's mission. Perhaps it was compassion fatigue or burnout that led him into all out rebellion against the church and state being declared an "enemy of the state" in 1936. He joined the Abwehr in 1939 and got involved and espionage and violent resistance, even helped in the attempt to assassinate Hitler. These actions cannot be seen as the extreme world views or modus operandi of a theologian and pastor, unless of course, one considers the possibility of burnout and or compassion fatigue with regards to the traditional German Christian school of thought. Perhaps, he was vulnerable by virtue of his chosen occupation. That is, simply being a public servant or a minister of compassion ate care inevitably makes one vulnerable to the possibility of fatigue or burnout. This is especially true when one's own survival and well-being are put on the line. After all, we are "only human," but how did the ideas of compassion, compassion fatigue and burnout impact the earthly life and ministry of Jesus?

Well from the start no one familiar the biblical narrative of his earthly ministry can deny the fact that Jesus spent most of his ministry dealing with resistance and opposition. Jesus was constantly under the pressures of suspicion, duress and danger.

All in response to what can legitimately be called compassionate care. Jesus was no ordinary human being. He was "the Son of God" and "the Son of Man" occupying the same time, place, and person. Jesus is known throughout Christian history as the "consubstantial" second person of the "Holy Trinity." He operated in the most ultimate form of love, agape love. Whereas most human beings spent most of their lives operating from a praxis of either the form of love known as "Eros"[40] (romantic, affectionate love) or the one referred to as "philos" (brotherly love).[41] These forms of love are believed to be more innate, a natural part of human life, relations and interactions. In other words, they tend to originate from within heart and God-given capacity of humanity. However, a third form of love is known as agape love. God is the only source of agape love.[42] By its very nature its self-sacrificing, self-surrendering and unconditional. This makes it supernatural. Moreover, as a member of the Holy Trinity, Jesus was also empowered by the supernatural power of the Holy Spirit, (Matt 3:16, Lk 4:1, Lk 4:14-21, and Jn 1:32). The *Holy Bible* also informs us that as the "Son of Man" Jesus also shared various human traits such as hunger (Matt. 4:2), thirst (Jn 19:28), tiredness (Jn 4:6), and even anger (21:12). Essentially, Jesus during his earthly existence was "tempted in every way, just as we are—yet without sin, (Heb. 4:15). He literally walked in unconditional love and supernatural power and because of his perfect obedience and faith, He has been declared the Great High Priest of humanity (Heb. 4:15).

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[40] William Bauer, *A Greek-English Lexicon of the New Testament and Other Early Christian Literature* (Chicago, IL: University of Chicago Press, 1979), 310.

[41] James Strong, *Strong's Exhaustive Concordance: Complete and Unabridged Compact Edition* (Ada, MI: Baker Book House, 1983), 76.

[42] Bauer, *A Greek-English Lexicon*, 6.

Therefore, I feel certain that in His humanity, Jesus Christ, while subjected to human emotions, and frailties, was never vulnerable to, or at risk for compassion fatigue or burnout. He may have experienced an array of emotions and stressors but never to the point of fatigue or burnout. His distress was most vividly displayed in two places during his passion narrative, in the Garden of Gethsemane and on the cross. In the garden, Jesus confessed to his disciples that his soul was "sorrowful even to the point of death (Matt. 26:35)." After petitioning God for relief from his pending suffering three times in prayer, he concluded, "not my will, but thy will be done" (Mk. 14:36, Lk. 22:42). He walked away from the garden with the resolve to carry-out his mission. Moreover, on the cross when Jesus let out a rip-roaring shout, "My God, My God why has thou forsaken me?" (Matt. 27:46). In these two scenes Jesus' humanity was on full display, yet he never waved in doubt and unbelief. He never quit, even thou he had a viable out whenever he chose to utilize it. He once scolded Peter for cutting off Malchus' ear reminding him that anytime he wanted he could have summonsed twelve legions of angels for deliverance (Matt. 27:52). As referenced in the Biblical Foundation chapter, fourth century Bishop of Milan, Ambrose wrote of Jesus' dual nature:

> *His Recollection of Psalm 22. Ambrose*: As a human he doubts. He experiences amazement. It is not his divinity that doubts, but his human soul. He had no difficulty being amazed because he had taken upon himself a human soul. As God he was not distressed, but as human he was capable of being distressed. It was not as God that he died, but a man. It was in human voice that he cried: My God, My God, why have you forsaken me? As a human therefore, he speaks on the cross, bearing with him our terrors. For amid dangers it is a very human response to think ourself abandoned. As human, therefore, he is distressed, weeps, and is crucified. (On the Christian Faith 2.7.56)[43]

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[43] Thomas C. Oden and Christopher A. Hall, eds., *Ancient Commentary on Scripture: New Testament II, Mark* (Downers Grove, IL: Intervarsity Press, 1998), 222.

Yet never once did Jesus show a single symptom of anything likened to fatigue and burnout. In fact, it can be argued that Jesus may have exemplified the notion of compassion satisfaction in that he delighted in doing the will of the God and was confidently able to proclaim after the cry of dereliction, "Father into thine hands I commend my spirit," (Lk. 23:46). Jesus models for all of us what to do with our stresses or worries, cultivate healthy self-care techniques (his was spirituality and prayer) as a means of remaining effective in our missions. How does one know when he or she is at risk for compassion fatigue or burnout?

For the purposes of this project a couple measurement will be employed which are very common in the social sciences where studies of compassion fatigue and burnout are concerned, the SCAW and Pro-QOL scales. They will each be discussed below in this order.

Self-Care Assessment Worksheet (SCAW)

The SCAW is an acronym for the Self Care Assessment Worksheet. It was original developed in 1996 by Psychologist Karen W. Saavitne and Anne Pearlman as a part of a workbook developed to help people with "vicarious tramatization."[44] It was designed to be an indicator that measures the degree to which individual engage in self-care activities and or strategies. The tool is comprised of six subscales which measure areas of self-care physical, psychological, emotional, spiritual, professional workplace,

[44] Karen W. Saavitne and Laurie Anne Pearlman, *Transforming the Pain: A Workbook on Vicarious Traumatization* (New York, NY: W. W. Norton and Company, 1996).

and balance.[45] Each subscale presents a different number of items assessing an array of self-care strategies engaged or employed by the respondents. Respondents are instructed to rate each activity on a scale of one to five in terms of the frequency with which they are engaged. The range in this Likert Scale goes from one meaning the activity never occurs, to five meaning it occurs frequently. Alkema (et. al) identified the following as samples from the SCAW: a) eat regularly (physical), make time for self-reflection (psychological), allow yourself to cry (emotional), d) be open to inspiration (spiritual), e) take time to chat with co-workers (workplace), and f) strive for balance among work, family, relationships, play, and rest (balance). The possible scores with SCAW subscales depend on the number of items addressed within each. For example, on the Spiritual Care subscale there are seventeen items, on the Physical Care scale fifteen items, and on the Emotional eleven. Accordingly, higher scores on the SCAW are indicative of more engagement with self-care activities, while lower scores indicate minimal self-care initiatives. Interestingly, Alkema (et. al.) found positive correlation between compassion satisfaction and all six subscales of the SCAW. It also found negative correlations between compassion fatigue and burnout and all six SCAW subscales. This seems consistent with this project's hypothesis that educational and application of better self-care initiatives are effective remedies to compassion fatigue. In this research project the SCAW will be used as both a pre and post-workshop measurements participant's awareness and or engagement of self-care initiatives. If the project's hypothesis holds true there should be noticeable difference in the pre and post-workshop SCAW results.

[45] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 108, accessed March 29, 2019, http://www.hawortpress.com.

ProQOL-V

Professional quality of life is the quality individuals feel in relation to their work as helpers of others. Both the positive and negative aspects of doing your work can influence your professional quality of life. People whose work involves helping others may be called to respond to individual, community, national, and even international crises. They may be health care professionals, social service workers, teachers, attorneys, police officers, firefighters, clergy, transportation staff, disaster responders, and others. Understanding the positive and negative aspects of helping those who experience trauma and suffering can improve your ability to help them and your ability to keep your own balance. While ProQOL-V is an appropriate tool for any of the helping professions listed, the focus of this project is limited to hospice workers.

The Profession Quality of Life Assessment Tool (ProQOL-V) measures aspects related to care giving professionals' quality of life. It was originally developed by Dr. Charles R. Figley in 1995 as the compassion fatigue Self-Test. It was revised and further advanced and developed by Dr. Beth Hudnall Stamm.[46] The ProQOL is the most commonly used measurement of the negative and positive effects of helping others who experience suffering and trauma. While there have been several revisions over the years the ProQOL-V is the most current version. The instrument consists of three different sub-scales: compassion satisfaction, compassion fatigue and burnout. Each sub-scale consists of ten statements designed to assess behaviors which could lead to compassion fatigue. Participants were asked to rate each statement as it applied their particular and current situation. Each statement then was an independent variable and was analyzed and

[46] "Professional Quality of Life Measure: ProQOL.org," Center for Victims of Torture, last modified 2019, accessed April 28, 2019, https://ProQOL.org/Home_Page.php.

grouped to produce risk factors. It is important to note the subjective nature of the instrument. Like the SCAW sub-scale scores are derived primarily from self-report indicators. Thus, results can only be used comparatively, not to make any kind of diagnosis. Nonetheless, the Alpha reliabilities for the subscales are as follows: compassion satisfaction ($\alpha = .87$), burnout ($\alpha = .72$), and compassion fatigue ($\alpha = .80$). In other words, this scale's reliability has held strong throughout the years. This scale along with the SCAW will be used to identify potential risk factors in participants and to offer remedy via educational programming. The ProQOL-V will be used in this project to initially identify where participants are on the scale for compassion satisfaction, compassion fatigue and burnout. This information will then be weighed against what was gained from the SCAW pre and post-workshop surveys.

Interview

The final part of this project will be a forty-five minute to one-hour exit interview between this myself and each participant. The purpose of the interview is to assess whether or not the participants awareness of the importance of education, and self-care with regards to compassion fatigue and burnout increased as a result of this project. The questions will also offer insight to Vitas' management in term of the efficacy of its own employee support initiatives. It is believed that with education caregivers will be equipped and empowered to effectively deal with the occupational related risks around the subject matter. The questions used here are modified version of those originally used

by researcher Christina S. Melvin in her work with compassion fatigue among hospice professional.[47] The questions employed for the interview are listed below:

1. How many years have you worked in hospice and palliative care?
2. Describe how you cope with ongoing patient deaths and the families following these death?
3. Professional compassion fatigue is described as having the potential of causing negative effects for those who continually care for patients who are seriously ill, wounded, traumatized and the dying.
    a. What are your thoughts about this?
    b. Do you have any feelings around this concept?
    c. Have you ever experienced any distressing symptoms related to this work (nightmares, difficulty sleeping, intrusive thoughts, depression, etc.)?
    d. Has your view of death changed since you began this work?
    e. When you return from vacation, do you feel refreshed or rejuvenated?
    f. How would you know if you needed a break from hospice or palliative care?
    g. Describe what coping strategies were before this workshop?
    h. What role does your manager or company play in supporting you in this area of practice?
    i. Do you feel supported by your manager/employer?
    j. Describe what you found most helpful about this course?
    k. Do you have any recommendations for other hospice employees which might enable them to continue in this field over a long period of time?

[47] Christina S. Melvin, "Professional Compassion Fatigue: What is the True Cost of Nurses Caring for the Dying," *International Journal of Palliative Nursing* 18, no. 12 (2012): 607, accessed May 5, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=1&sid=5175b41e-1e88-4c42-bdb3-2dcabd55896f%40pdc-v-sessmgr01.

Finally, it is a well-researched and documented fact that people who spend their lives and careers helping people do so at great personal emotional and maybe even psychological costs. Unfortunately, these discoveries were just made over the past few decades and are yet evolving. Just because something has yet to be discovered does not mean that it and its impact were any less significant. Perhaps this explains Fr. de Veuster's years of cynicism and antagonisms with the Hawaiian government. Maybe it explains why Bonhoeffer broke with the German Christian church and, in the eyes of some, went rouge. It may even, at least from a human perspective, explain Jesus' cry of dereliction on the cross, "My God, My God, why has thou forsaken me?" It certainly offers insights into my personal struggles as adult survivor of abandonment related issues and as someone who has spent the past thirty-five years in the human helps business. Therefore, I sincerely hope and pray that the findings of this research may prove helpful to the countless other kind, committed and selfless people who dedicate their lives being extensions of God's love and compassion to others.

CHAPTER SIX

PROJECT ANALYSIS

Introduction

Most of those who commit their lives and careers to helping others usually do so from a deep sense of calling. They have a sincere concern and compassion for others. They want "help" to make a difference in the lives of people. This is true for those in the fields of hospice and ministry alike. Hospice workers meet terminally ill patients and families in very vulnerable and difficult circumstances. They tirelessly commit to the alleviation of physical, emotional, and spiritual suffering by means of symptom management, and affirmation of human dignity. Ministers seek to serve God by serving people, often meeting them "where they are," caught up somewhere in the vicissitudes of the human condition, with a message of hope and renewal. Yet, for both disciplines compassion comes at a cost.

Dr. Charles Figley's work on compassion fatigue and burnout reminded us that it is literally impossible for individuals to be exposed to human suffering without being emotionally and psychologically impacted in the form of internalized stress. Subsequently, caregivers with unprocessed and untreated stress are believed to be at risk for distress which can have adverse effects on human well-being. In fact, Figley suggested that compassion fatigue and burnout are two examples of these occupation related psycho-emotional hazards. This dissertation project limited its focus to the issue

of institutional abandonment by questioning what responsibility employers or institutions, whether healthcare or religious, bare in helping care for at risk caregivers.

The original context for this inquiry was the Mt. Zion Church of Connersville, Indiana. Then the focus was on abandonment as a result of derelict pastoral leadership. However, during my second year in this Doctor of Ministry program, my ten-year tenure with Mt. Zion came to an end, which necessitated a change of context. The current context is Vitas Healthcare, a national provider of hospice care. Due to the constraints imposed on this inquiry by switching from a religious to a secular context, the focus also shifted from pastoral abandonment to institutional abandonment. I have been employed in the current context, Vitas Healthcare, for the past eighteen years and currently serves as the bereavement services manager. Vitas is a national provider of hospice care for terminally ill patients and their families. Since 1978 it has been the nation's leading provider of these services. It is the reputed "gold standard" of hospice care in America. However, my "in-siders" assessment suggests that not enough is done across the healthcare industry to systematically or programmatically care for caregivers. This also holds true for the almost 13,000 men and women employed by Vitas.

If Figley's theory is correct; then Vitas could have a whole lot of distressed individuals in its ranks. Failure to implement effective means of employee support initiatives and or educational programming may very well constitute a kind of institutional abandonment. This not only affects the personal lives of employees but could also impact patient care and the company's overall viability. Therefore, this project set out to answer three questions. First, are employees in Vitas' Cincinnati program at risk for compassion fatigue and burnout? Second, will educational

programing increase individuals' awareness of the need to engage effective self-care measures? Finally, how can such findings help the company as a whole? My hypothesis for this project was that educating participants on the nature and risks of compassion fatigue and burnout would prove an effective diversion or remedy to it.

Methodology

As discussed in chapter five, this project employed a phenomenological qualitative research design which sought to gain insight into and awareness of the psychosocial and emotional hazards or risks of hospice work as a diversion to fatigue and burnout. Participation in the project was completely voluntarily. Initially, twelve participants were invited to be a part of the subject group. The participants represented a cross section of the six interdisciplinary groups from Vitas' Cincinnati Ohio program. On average, the Cincinnati program treats over 300 patients and families on a daily basis. Although twelve participants were actually invited to participate in this project, thirteen participants actually showed up for the first class/workshop. However, only nine were able to complete the six-week curriculum. These included one physician, one team manager, two social workers, one chaplain, one team secretary, and three CNAs. Each discipline interfaces with patients and families on a regular basis on the continuum of patient care. All team members are expected to establish trust and rapport via compassionate caring and presence. Moreover, all of them are constantly exposed to human suffering and all the other traumas, stresses, and strains that accompany the dying process. Therefore, the participants of this project are great candidates with regards to project's inquiry.

As discussed in chapter one, this projects' guiding hypothesis was that educating caregivers on best practices and techniques of providing self-care is an effective way to raise awareness of the importance thereof and is an effective diversion of compassion fatigue and burnout. The project's design consisted of the following factors: pre and post workshop surveys, a six-week educational workshop on compassion fatigue, burnout, and self-care, and a thirty-minute exit interview. The methods of triangulation included administering of two pre and post workshop surveys, (the ProQOL-V & SCAW), and an exit interview. There were three learner's goals for the project. First, participants gained insight and understanding into the nature and causes of compassion fatigue and burnout. Secondly, participants were able to personally identify with course material relevant to their own roles as hospice workers. Thirdly, participants gained an increased awareness of the importance of maintaining good personal mental, emotional, social, and spiritual hygiene or self-care. The Pro-QOL, SCAW, six-week workshop, and exit interview will be outlined in detail below.

Self-Care Assessment Worksheet (SCAW)

SCAW is an acronym for the Self-Care Assessment Worksheet. It was originally developed in 1996 by psychologist Karen W. Saavitne and Anne Pearlman as a part of a workbook developed to help people with "vicarious traumatization," (another term for compassion fatigue).[1] It was designed to be an indicator that measures the degree to which individuals engage in self-care activities and or strategies. The tool is comprised of six subscales which measure areas of self-care: physical, psychological, emotional,

[1] Karen W. Saavitne et al., *Transforming the Pain: A Workbook on Vicarious Traumatization* (New York, NY: W. W. Norton and Company, 1996).

spiritual, professional workplace, and balance.[2] Each of the subscale presents a different number of items assessing an array of self-care strategies engaged or employed by respondents. Respondents were instructed to rate each activity on a scale of one to five in terms of the frequency with which they were engaged. The range in this Likert Scale that spans from the number one meaning the activity never occurs, to five meaning it occurs frequently.

Alkema (et. al) identified the following as samples from the SCAW: a) eat regularly (physical), b) make time for self-reflection (psychological), c) allow yourself to cry (emotional), d) be open to inspiration (spiritual), e) take time to chat with co-workers (workplace), and f) strive for balance among work, family, relationships, play, and rest (balance). The possible scores with SCAW subscales depend on the number of items addressed within each. For example, on the spiritual care subscale there are seventeen items, on the physical care subscale there are fifteen items, and on the emotional there are eleven. Accordingly, higher scores on the SCAW are indicative of more engagement with self-care activities, while lower scores indicate minimal self-care initiatives. Interestingly, Alkema (et. al.) found positive correlations between compassion satisfaction and all six subscales of the SCAW. It also found negative correlations between compassion fatigue and burnout and all six SCAW subscales. In other words, cultivating a lifestyle of intentional self-care initiatives is an effective meaning of coping with vicarious trauma and burnout. This is especially true for emotional care, spiritual

[2] Karen Alkema, Jeremy M. Linton, and Randall Davies, "A Study of the Relationship between Self-Care, Compassion Satisfaction, Compassion Fatigue, and Burnout Among Hospice Professionals," *Journal of Social Work in End-of-Life and Palliative Care* 4, no. 2 (February 2008): 102, accessed March 29, 2019, http://www.hawortpress.com.

care, and work-life balance.[3] This seems consistent with this project's hypothesis that educational programming and application of better self-care initiatives are effective remedies to compassion fatigue. In this research project the SCAW will be used as both a pre and post-workshop measurements of participant's awareness and or engagement of self-care initiatives. If the project's hypothesis is true, there should be noticeable difference in the pre and post-workshop SCAW results.

ProQOL-V

Professional quality of life refers to the level of satisfaction or fulfillment that individuals in "helping" careers feel in relation to their work. Both the positive and negative aspects of doing one's job may influence his or her professional quality of life or at least the perception thereof. The Profession Quality of Life Assessment Tool (ProQOL-V) measures three potential affects related to the care giving professionals' quality of life. It was originally developed by Dr. Charles R. Figley in 1995 as the compassion fatigue self-test. It was later revised and further developed by Dr. Beth Hudnall Stamm.[4] The ProQOL-V is most commonly used to measure the negative and positive effects of helping others who experience suffering and trauma. While there were several revisions over the years, the ProQOL-V is the most current version. The instrument consists of three different sub-scales: compassion satisfaction, compassion

[3] Alkema, Linton, and Davies, "A Study of the Relationship between Self-Care," 113, accessed March 29, 2019, http://www.hawortpress.com.

[4] "Professional Quality of Life Measure: ProQOL.org," Center for Victims of Torture, last modified 2019, accessed April 28, 2019, https://ProQOL.org/Home_Page.php.

fatigue and burnout. Each sub-scale consists of ten statements designed to assess behaviors which could lead to compassion fatigue or burnout.

Participants were asked to rate each statement as it applied to their particular situations. Each statement was viewed as an independent variable and was analyzed and grouped to produce risk factors. It is important to note the subjective nature of the instrument. Like the SCAW sub-scale scores are derived primarily from self-report indicators. Thus, results can only be used comparatively, not to make any kind of diagnosis. Nonetheless, the Alpha reliabilities for the subscales are as follows: compassion satisfaction ($\alpha = .87$), burnout ($\alpha = .72$), and compassion fatigue ($\alpha = .80$). In other words, this scale's reliability has held strong throughout the years. It is my intentions to use this scale along with the SCAW to identify potential risk factors in participants and to offer a remedy via educational programming. The ProQOL-V was used in this project to initially identify where participants were on the scale for compassion satisfaction, compassion fatigue and burnout. They were also asked to complete this scale once following the six weeks of classes. Any information gained via the pre and post ProQOL-V scales, the SCAW surveys and the interviews was then analyzed to determine the validity of the hypothesis.

Interview

The final part of this project involved a thirty-minute exit interview between each participant and me. The purpose of the interview was to assess whether or not the participant's awareness of the importance of self-care as a diversion to compassion fatigue and burnout increased as a result of this project. The questions also offered

insight to Vitas' management in terms of the efficacy of its own employee support initiatives. It is believed that with education caregivers will be equipped and empowered to effectively deal with the occupation related risks around the subject matter. The questions used were a modified version of those originally used by researcher, Christina S. Melvin, in her work with compassion fatigue among hospice professional.[5] The questions outlined in chapter five were used for these interviews.

Implementation

The originally proposed timeline for this project was between July 1 and August 12, 2019 for the preliminary work, the workshops and follow-up interviews. However, due to unforeseen changes in the context, the project's start date was changed from July 1 to September 10, 2019. The preliminary work took place between late July and early September. It included researching and gathering all forms like the SCAW, PROQOL-V and interview questions. It also included consulting with context associates, and cohort partner Rev. Matthew Williams regarding project plans and design. I also took this time to recruit and strategize with guest workshop instructors for weeks five and six, Aruni Marapane and Dr. Michelle Gary-Owensby. Next, I recruited twelve participants among three of the program's six interdisciplinary groups (teams) that hold their weekly team meetings on Thursdays. For that reason, Thursday was seen as the best day to hold the workshop. Two teams met from 8:30 am until 11:30 am and another one met from 1:00 pm until 4:30 pm. Therefore, it was believed that the only way to get this many field-

[5] Christina S. Melvin, "Professional Compassion Fatigue: What is the True Cost of Nurses Caring for the Dying," *International Journal of Palliative Nursing* 18, no. 12 (2012): 607, accessed May 5, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=1&sid=5175b41e-1e88-4c42-bdb3-2dcabd55896f%40pdc-v-sessmgr01.

based employees to participate was to catch them while they were already in the office. Recruitment activities included attending each team meeting and "pitching" the project and asking for volunteers and some by personal invitations. For reasons stated above the determination was made to hold the workshops on Thursdays from 12:00 pm until 1:00 pm. Lunch was provided to accommodate the 8:30 am and 1:00 pm groups for any inconvenience which participation might incur.

Further, it is important to mention that an important member of the Vitas Healthcare team was not able to participate in this project for practical reasons. Intensive Continuous Care (ICC) is a service put in place for patients who experience significant status changes necessitating more one-to-one supervision. Often these patients are imminent and close to transition. ICC is staffed by CNAs during normal working hours and Licensed Practical Nurses (LPNs) at night for medication purposes. They work in twelve-hour shifts. They are with families prior to, during, and immediately following the death experience. In fact, ICC staff are trained not to leave a patient's home or nursing facility until the patient's body leaves after death. Thus, they unlike many, constantly face the emotional weight and complexities of the dying process with families; often with little-to-no emotional support, reassurance, or chance to debrief. I especially wanted their input on this project. Unfortunately, due to the meeting times and schedule constraints, their involvement was not possible.

The actual workshops were schedule from 12:00 pm and 1:00 pm following Thursday's team meetings September 14 through October 10, 2019. A final workshop occurred on October 25, 2019. Thursday October 17, 2019 was omitted due to the mid-semester cohort meeting in Georgia. Once more, workshops consisted of six separate

meeting or classes. During the first class, participants were randomly assigned a number and instructed to write it in upper left corners of their consents forms and scales and to remember those assigned numbers throughout the course. The same numbers were applied to post-workshop scales and the exit interview. Next, participants were instructed to complete and sign the Human Subject Consent forms, the pre-workshop SCAW and the ProQOL-V scales during the first workshop. It should be mentioned that the Human Subject Consent forms and curriculum were read aloud; and all questions were addressed during this first workshop. Participants were asked to commit to the entire six-week program. However, they were informed that one absence would be allowed with make-up requirements. All of the original thirteen participants completed all necessary paperwork.

Classes two and three were primarily instructional on the theoretical and historical background of the study of compassion fatigue and burnout. Participants all received a copy of a sixty-slide power point presentation on the subject matter. The presentation distinguished between sympathy, empathy, and compassion in patient care. Next, we reviewed research and literature dating back to 1982 on vicarious traumatization, stress, and distress and related risk factors for healthcare and hospice workers. Figure one shows a copy of Charles Figley's model of compassion fatigue resilience as introduced during these two classes. Again, according to Figley anyone engaged in providing relief or care of traumatized human beings are at risk for compassion fatigue or burnout. Yet, there is a remedy, compassion satisfaction.

Compassion satisfaction is a state in which one finds fulfillment, meaning and purpose in their work as opposed to exhaustion or exasperation. However, one's ability

to attain compassion satisfaction is largely dependent on the supports and coping strategies he or she employs. In other words, longevity, effectiveness, and contentment in trauma workers are largely dependent on the quality of one's level of self-care, professional detachment, sense of satisfaction, and social supports. These presentations ended with an overview of the importance of cultivating healthy self-care as a way of life.

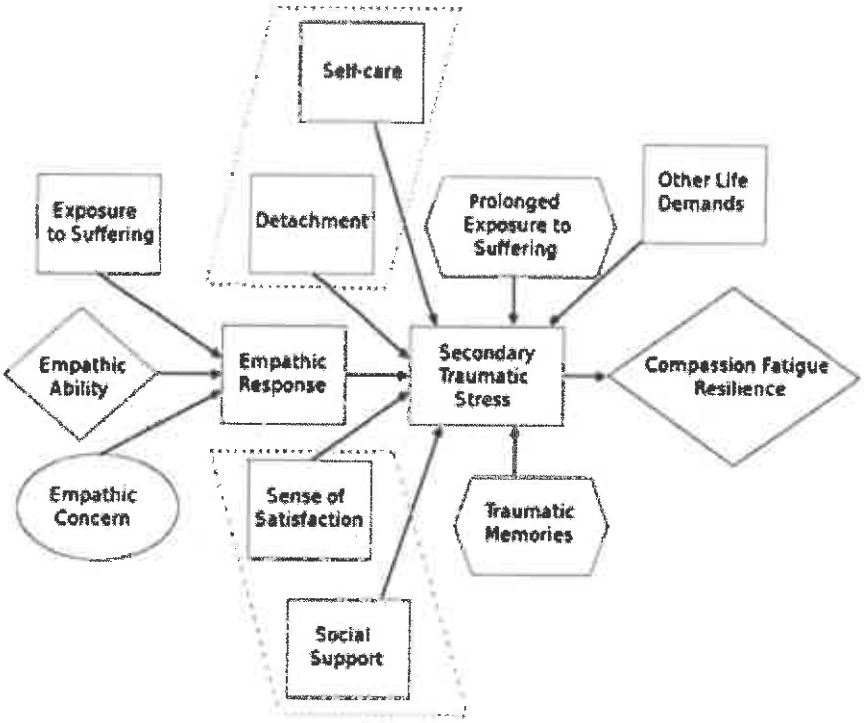

Figure 1. Charles Figley's model of compassion fatigue resilience

Class four involved a group discussion. The goal here was to give participants an opportunity to personally reflect on and engage, share their thoughts, feelings and responses regarding the materials presented in classes two and three. Prior to this meeting two participants were approached and asked if they would be willing to share their personal experiences with work related stress (as they had both shared their stories with me previously). One was a CNA and the other a SW. I then connected their stories back to content covered during classes two and three. This was followed by an extensive

group discussion on the subject matter. This became a very cathartic experience for all involved as one by one people started releasing suppressed thoughts and feelings about unaddressed stressors in their lives. People became very tearful and emotional. This actually morphed into a kind of support group. Two of the more common sentiments expressed were "It's helpful to know I'm not alone with this," and "It's a relief to finally be able to name what's wrong with me."

Unfortunately, class five did not go as planned and anticipated. During this session context associate Aruni Marapane, a Buddhist Chaplain, was scheduled as a guest lecturer. She was supposed to present on self-care from a Buddhist perspective. Her talk was to include relaxed breathing, meditation, and yoga exercises. However, two weeks prior to the date of her presentation, her mother-in-law in India got sick and Aruni and her husband went to be at her side. We were unable to get someone to replace her with such short notice. Therefore, I found an educational video on the subject to suffice. The lecturer was Dr. Barry Kerzin, an American physician and Buddhist Monk. He lives in India and serves as a personal physician to the Dalai Lama. The context of his 2015 lecture was the Foreign Correspondents Club of Hong Kong. He was a guest speaker during one of the club's luncheons. His topic was "A Lesson in Meditation, Compassion

and Stress Management.[6] His talk was on mindfulness, self-awareness, and the importance of self-care. He ended his talk with a guided meditation. The class participated in the guided meditation and reported that it was very relaxing. Three people reported that they almost fell asleep. Overall, the group found the video presentation to be very informative and helpful.

The presenter for the sixth and final class, Dr. Michelle Owens-Gary, a Clinical Psychologist and Behavioral Scientist with the Centers for Disease Control and Prevention. She spoke on the topic, "Called to Care: Addressing Compassion Fatigue Among Hospice Workers." She spoke from a thirty-five-slide power point presentation entitled "Called to Care: Addressing Compassion Fatigue Among Hospice Workers." The presentation began with a concise overview of the nature and risk factors involved with compassion fatigue. She then stressed the importance of self-awareness, balance, and heathy coping strategies as a means of achieving compassion satisfaction. Her presentation was interactive including both exercises and discussion. The class was receptive and engaging throughout her talk. At the conclusion of the last class, participants were asked to complete the post SCAW and ProQOL-V surveys and

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[6] Barry Kerzin, "A Lesson in Meditation, Compassion and Stress Management," accessed October 11, 2019, https://video.search.yahoo.com/yhs/search;_ylt=AwrC_DOEMCNenzUA_BUPxQt.;_ylu=X3oDMTB0N2Noc21lBGNvbG8DYmYxBHBvcwMxBHZ0aWQDBHNlYwNwaXZz?p=dr+berry+kerzin+compassion+fatigue&type=smymbds_aexhvyozmlyxdfhjlnpxhe_19_14_ssg20_ag24315&hspart=itm&hsimp=yhs-001&param1=1&param2=f%3D4%26b%3Dchrome%26ip%3D74.83.127.4%26pa%3Dsearch-manager%26type%3Dsmymbds_aexhvyozmlyxdfhjlnpxhe_19_14_ssg20_ag24315%26cat%3Dweb%26a%3Dsmymbds_aexhvyozmlyxdfhjlnpxhe_19_14_ssg20_ag24315%26xlp_pers_guid%3De36a669e98a9d2e3f1d2f5e164398164%26xlp_sess_guid%3De36a669e98a9d2e3f1d2f5e164398164-95b4-7dc702492b1f%26uref%3D%26abid%3D20188%26xt_abg%3D24315%26xt_ver%3D10.1.4.55%26ls_ts%3D1554174972&ei=UTF-8&fr=yhs-itm-001#action=view&id=6&vid=0662a7d0d1a3a8cbf23adf1c4e1fdbb2.

schedule a time for their one-to-one interviews. All exits interviews were completed between October 24 and November 7, 2019.

Summary of Learning

This summary of learning is broken into four parts. First, it analyzed the data gathered from the Professional Quality of Life Survey-V (ProQOL-V) and expound upon insights gleaned herein. Second, this section analyzed and interpreted data from both the pre and post SCAW scales. It was expected that at the end of the workshops there should be some significant difference between data acquired from pre and post SCAW scales. Third examined information gleaned from the one-to-one interviews with workshop participants. This section ended with a review of lessons learned by all involved, me and participants, as a result of engaging in this project.

It is important to note that the ProQOL-V survey was designed to be an indicator of possible risks and symptoms of compassion satisfaction, burnout and compassion fatigue. Its design was a self-report-based model which offered insight into where the participants rate regarding their individual and collective sense of well-being or quality of life. It was divided into the three afore mentioned categories or subscales: compassion satisfaction, burnout, and compassion fatigue, respectively. The possible subscale scores and their meaning were presented in Table 1. As discussed above, participants were instructed to complete this survey during the first class. Initially, thirteen people showed up for the first class. However, four people dropped out and were unable to complete the entire six-week workshop. Reasons cited primarily had to do with scheduling difficulties. After all, this is healthcare and things can be very unpredictable from day to day.

Nonetheless, nine participants completed the entire process. Table One displays all possible points per subscale on the ProQOL-V.

Table 1. Cut points for professional quality of life assessment scales

Subscales	Low	Average	High
Compassion Satisfaction	0-32	33-41	42-50
Burnout	0-19	20-28	29-50
Compassion Fatigue	0-8	9-17	18-50

The first subscales measure various factors associated with compassion satisfaction (CS). It measured the level of satisfaction one derives from being able to do his or her job well. The possible scores range from zero to fifty points. Participants were instructed to rate eight different statements on a scale of one to five; one meaning never and five meaning very often. The average score for this subscale is thirty-seven.

According to Dr. B Hudnall Stamm, the scale's designer, about 25% of participants will score higher than forty-one and 25% score lower than thirty-three. Higher scores on this subscale indicates that caregivers derive a high level of satisfaction and fulfillment in their work. Scores lower than thirty-three may mean that individuals are displeased or dissociated from their jobs. However, for this project among all nine participants the low score was seventeen and the high score was twenty-five for an average of twenty-one on the pre workshop CS portion of the assessment. Post workshop scores were not much different with a low score of twelve and a high score of twenty-one for an average of twenty. Both pre and post results are more than fifteen points below that national average for compassion satisfaction. Further, participants one, two, four, nine and twelve seemed to score higher on the pre-class survey than on the post-class survey. This was admittedly unexpected. My hypothesis for this project suggests with educational programming, such as that offered during the six week-class, survey scores

should increase. That did not occur here. One possible explanation of these is the extreme concurrent stressors in the workplace. The latter portion of 2019 Vitas suffered massive turnovers across all disciplines meaning that those who remained had to endure many additional burdens in the interim. Another possible explanation is that there was not enough time between acquiring new information and actually implementing it one's daily life. More will be said about this later in this chapter. Nonetheless, these results seem to suggest a tremendous deficit in employee satisfaction and or morale at Vitas Healthcare in Cincinnati. Participant's scores for the compassion satisfaction subscale are demonstrated in the bar graph in Figure Two.

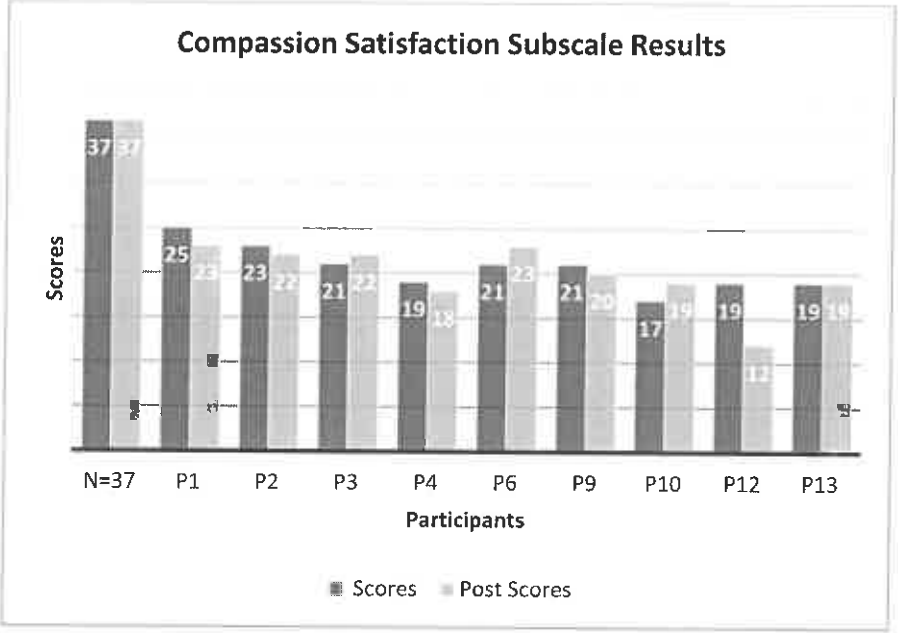

Figure 2. Compassion satisfaction subscale results

The second part of the ProQOL-V assessment focusses on burnout. For the most part, burnout is associated with feelings of hopelessness and despair in dealing with one's work or work context. It refers to the psychosocial, psychological, and or emotional difficulties in dealing with work or doing one's job well. These negative feelings and affects generally have a gradual onset. They usually occur over time in the context of

demanding workloads in non-supportive work environments. According to Stamm, the average score on burnout subscale of ProQOL-V is twenty-two. Accordingly, about 25% of participants score above twenty-seven and 25% score below eighteen. Here lower scores reflective greater levels confidence in one's ability to be effective in his or her work and work environment. Higher scores mean that one is at risk for burnout. The pre and post-class scores for Vitas Healthcare are reflected in the bar graph in Figure Three. Once more, the average on pre and post scales doubles that of the national norms. Further, the results continue to be mixed. Participants one, two, three, four, ten and twelve showed some decrease in their post-class scores, while participants six, nine and thirteen each yielded high post-class scores. Again, this variation may best be explained by contextual stressors and time limitations. A third possible explanation is that with such high scores some participant's needs may already exceed the need for awareness training meaning that they began this process already fatigued or burned out needing therapeutic interventions. This data seems to support the notion that some of the participants may be at risk for burnout if they are not already there.

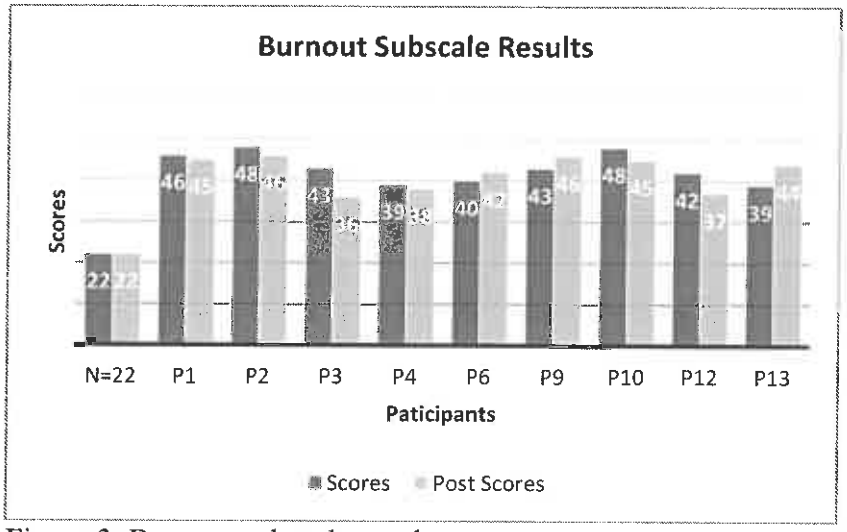

Figure 3. Burnout subscale results

Part three of the ProQOL-V addresses compassion fatigue (CF). The term CF is often used interchangeably with words like Vicarious Trauma or Secondary Stress (STS). They all point to work related, secondary exposure to stressful events. Examples of this includes those who work in emergency rooms, insurance adjusters or counseling where one is constantly confronted with real or storied human suffering. Thus, hospice workers, by the very nature of their work fall into this category of those possibly at risk for CF. However, CF or STS should not be confused with primary stress where one is directly in the path of danger such as soldiers, police officers, firemen and women or humanitarian relief workers. These are subject to primary stressors and are often at risk of contracting illnesses like Post Traumatic Stress Disorder. Compassion fatigue basically affects those in helping or serving professions who are constantly hearing of or witnessing human calamity and suffering. According to Stamm, the average score on this scale is thirteen. Once again, the model designer says that about 25% of participant are expected to score below eight and another 25% should score above seventeen on the ProQOL-V scale. However, for this participant group the pre-class low was nineteen with a high of twenty-three. 100% of the subjects scored above the national average, seventeen. The post-class low score was seventeen with a high of twenty-six. Here 89% of participants scored higher than seventeen. Viewed alongside the results of the compassion satisfaction and burnout subscales the ProQOL-V results suggest real concerns for the subject group. The ProQOL-V results may also be indicative of some kind of institutional neglect. This cross section of employees at Vitas Healthcare who are apparently baring up under low levels of job satisfaction and very high levels of stress may be in need of some very determined and deliberate employee support or engagement initiatives. Employee self-

care education is definitely needed. This is not to suggest that Vitas has been negligent, but they may simply not be unaware of the urgency of the need to implement more effective employee support initiatives. The results of the compassion fatigue subscale is outline in Figure Four.

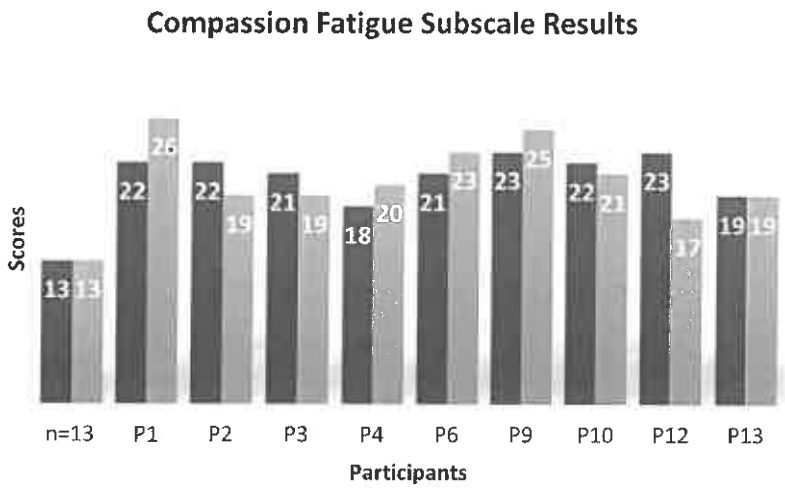

Figure 4. Compassion fatigue subscale results

The results for the ProQOL-V scale are summarized in table 2 and 3.

Table 2. Average ProQOL-V scores (pre)

Sub scores	N[a]	Mean	SD	Min. Sc	High Sc.
Compassion Satisfaction	9	20.5	2.4	17	25
Burnout	9	43	3.5	39	48
Compassion fatigue	9	21	1.7	18	23

Table 3. Average ProQOL-V scores (post)

Sub scores	N[a]	Mean	SD	Min. Sc.	High Sc.
Compassion Satisfaction	9	20	4.8	12	23
Burnout	9	42	4.0	37	46
Compassion Fatigue	9	21	3.0	17	26

The next scale used in this study was the Self-Care Assessment Work (SCAW). This tool is broken into six different categories all measuring the degree to which individuals engage in self-care or wellness activities. Accordingly, engaging effective wellness

activities is an important means of self-preservation and maintenance. The six areas of self-care on the SCAW are: physical care, psychological care, emotional care, spiritual care, workplace self-care, and balance. Each category consists of varying numbers of questions about some aspect of self-care. There was a total of seventy questions asked on the tool. Participants were instructed to answer each question on a scale of one through five, (five = frequently, four = occasionally, three = rarely, two = never, one = it never occurred to me). Here higher scores are indicative of healthy self-care practices and therefore a healthier sense of well-being and balance. The number in each of the six items and possible scores on the SCAW are summarized in Table Four.

Table 4. Number and possible scores of SCAW

Self-Care Area (Max)	# of questions	Min.Sc. (Min)	Max. Sc.
Physical Care	15	15	75
Psychological Care	13	13	65
Emotional Care	11	11	55
Spiritual Care	17	17	85
Workplace Self-Care	12	12	60
Balance	2	2	10

It is important to remember that SCAW is merely an indicator of personal care not a diagnostic tool. No Psychometric properties have been established for the SCAW. For the purpose of this study high scores represent high levels of engagement in self-care activities and low scores represent low levels of engagement. Further, it should be recalled that my hypothesis predicted that with increased education there should be measurable differences between pre and post class scores over the six-week period of the workshops. The results for the pre and post SCAW scores are summarized in Tables Five and Six below, and in Figure Five below.

Table 5. Average SCAW pre-class scores

Self-Care Area	N	Mean	SD	Min. Sc.	Max. Sc.
Physical Care	9	54.1	4.6	15	75
Psychological Care	9	44.9	8.1	13	65
Emotional Care	9	41.7	4.7	11	55
Spiritual Care	9	67.6	5.4	17	85
Workplace Self-Care	9	42.9	5.0	12	60
Balance	9	8.4	1.2	2	10

Table 6. Average SCAW post-class scores

Self-Care Area	N	Mean	SD	Min. Sc.	Max. Sc.
Physical Care	9	53.8	3.5	15	75
Psychological Care	9	41.7	3.4	13	65
Emotional Care	9	39.1	3.4	11	55
Spiritual Care	9	67.7	6.2	17	85
Workplace Self-Care	9	41	5.1	12	60
Balance	9	8.5	. 09	2	10

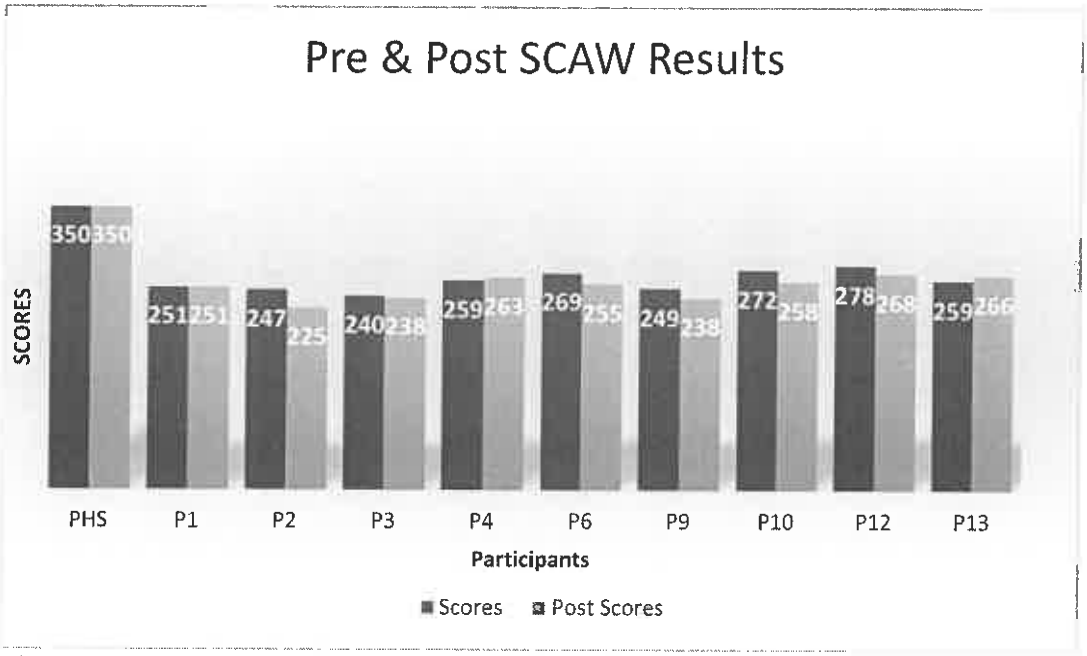

Figure 5. SCAW pre- and post-class scores

Tables Four and Five show how the pre-class and post-class SCAW assessments compared with regards to mean scores per category. In all but two categories, spiritual care and balance the pre-class average score was actually higher than the post-test. This

disproves the project's hypothesis. Similarly, the graph shows a great deal of variance in the results. Further, this point is also confirmed by reviewing the graph in Figure 5. The maximum cumulative score possible with the SCAW is 350. This is based on the highest possible scores for each category: seventy-five, sixty-five, fifty-five, eighty-five, sixty and ten, respectively. Participant one's scores were 251 for both the pre and post-class assessment. However, participants two, three, six, nine, ten and twelve scored higher on the first assessment than they did on the second. This too refutes the projects hypothesis. Only participants four and ten scored higher on the second assessment.

Moreover, the scores for both pre and post-class scales were significantly less than highest possible scores. The pre-class range was 21-31% points less than the highest possible scores yielding final scores between 69-79%. The post-class scores ranged from 24-38% lower yielding final scores between 62-76%. Once more, the post-class scores falling significantly lower than pre-class score. This is very interesting in that the data suggest sub-average to only average levels of engagement in self-care activities in this study group. While the SCAW's purpose is neither diagnostic nor psychometric, if one were to grade these scores on a traditional grading scale, the results would range from a D to C+ at best. As coping strategies these would appear to be woefully inadequate for a group of people living with twice the national averages for stress, according to the ProQOL-V results above. In fact, agreeing to commit to this six-week project may have further exacerbated their stress levels which might explain the discrepancies in the pre and post SCAW results. These inconsistencies may also offer insight into the machinations, decisions and behaviors of both Damien de Veuster and Dietrich

Bonhoeffer towards the end of their lives. Next we will look at the results from the exit interviews.

The final part of this project involved a thirty-minute exit interview between each participant and me. As stated earlier, the purpose of the interview was to assess whether or not the participant's awareness of the importance of self-care as a diversion to compassion fatigue and burnout increased as a result of this project. The questions also offered insight to Vitas' management in terms of the efficacy of its own employee support initiatives. It is believed that with education caregivers will be equipped and empowered to effectively deal with the occupation related risks around the subject matter. The questions used were a modified version of those originally used by researcher, Christina S. Melvin, in her work with compassion fatigue among hospice professional.[7] However, only six of them are analyzed below primarily because of their relevance to the questions being considered in this project. The following six questions will be addressed below:

1. How many years have worked in hospice and palliative care?

3c. Have you ever experienced any distressing symptoms related to this work (nightmares, difficulty sleeping, intrusive thoughts, depression etc.)

6. How would you know if you needed a break from hospice or palliative care?

8. What role does your manager or company play in supporting you in this area of practice?

9. Describe what you found most helpful about this course.

10. Do you have any recommendations for other hospice employees which might enable them to continue in this field over a long period of time?

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[7] Melvin, "Professional Compassion Fatigue," 607, accessed May 5, 2019, http://eds.b.ebscohost.com.ezproxy.uakron.edu:2048/eds/pdfviewer/pdfviewer?vid=1&sid=5175b41e-1e88-4c42-bdb3-2dcabd55896f%40pdc-v-sessmgr01.

Question 1

The time span of employment in the hospice field among the nine participants extended from three to four months to twenty plus years. Five participants have worked for Vitas for ten or more years; three for three and a half to seven years, and only one for three to four months. Interestingly, two of the five participants who have been with Vitas ten or more years, had the lowest scores on both the pre and post SCAW. They both work in the psychosocial department.

Question 3c

The answers to this questions are summarized in Table Seven below. All but one of the participants (#4) reported that they either currently are or have struggled with some occupation related adverse symptom. A couple of participant's response to this question were very revealing, offering insight into how these adversities might be experienced by hospice workers. The first was, "My work coupled with my personal life stressors got me to a point where I didn't like people anymore. I didn't want to see or talk to them. I just wanted to stay in bed, (Participant two)." The second explanation was "I find myself wrestling with guilt sometimes. I question myself wondering whether or not I did enough for my patients, (Participant nine).

Table 7. Response summary for question 3c

Symptom	P1	P2	P3	P4	P6	P9	P11	P12	P13
Depression	Yes	Yes	Yes				Yes	Yes	Yes
Irritability	Yes	Yes					Yes	Yes	Yes
Insomnia			Yes		Yes	Yes		Yes	
Guilt						Yes			
Int. Thoughts		Yes			Yes				
Anxiety									

Question 6

The responses to this question are summarized below in Table Eight. All but one participant (nine) reported experiencing intermittent negative emotional, psychological and or adversities directly related to occupation related stressors.

Table 8. Response summary for question 6

Participant	Response
1 -	"When I'm moody, irritable, fatigued, and grumpy"
2 -	"When I feel there's nothing more to give. It feels more mechanical than personal"
3 -	"When paperwork gets to me. When I feel sad, irritable, cynical, and like I'm dragging"
4 -	"When I'm physically exhausted and emotionally drained. Too much death"
6 -	"Yes. I have insomnia and intrusive thoughts."
9 -	"Not Sure. It's hard to dissociate myself from it."
11-	"When I feel exhausted impatient and irritable"
12-	"When I feel depressed or irritable."
13 -	"I get mean, introverted and want to be bothered, just do my work and go."

Question 8a

The participants were somewhat split on this question. Four of them felt that the company should and does support its employees. They offered examples such as management being the "first line of support" for employees by listening to them, being accessible and encouraging, offering paid time off (PTO) or Comp Time when needed. One participant even identified this project as an example of the company supporting employees. On the other hand, four participants were unable to describe ways in which employers can support their employees or identify ways they have been or felt supported.

One person reported that it was solely up to the employee to seek out the support that he or she needs.

Question 8b

Four participants responded yes. However, three of them were unable to identify specific ways that the company provided this support. One of them actually mistook this project as a company support initiative. Four participants reported not feeling supported by management. One of them reported feeling that support was selectively administered and based on favoritism. Another participant felt that all the company cares about is the bottom line and that employees were just expected to "keep producing." A ninth participant reported feeling uncertain or "not sure" about the question of management/company support of employees. This is problematic because if this sample is representative of the program as a whole then it implies that over 50% of Vitas' employees feel unappreciated, under-appreciated, and or unsupportive. This coupled with the stressors inherent in the work itself can contribute to compassion fatigue or burnout and can be perceived as a kind of institutional neglect.

Question 9

All nine participants agreed that the most helpful part the workshop for them was the group process, being with and supported by others. They used words like "community," "connecting," and "refreshing" to describe what the experience was like for them. They reported that listening to the stories of others was reassuring. They felt as if they were not alone in the struggles and distresses of the field, that they have a

common weight to bare that Bonhoeffer might describe as the "cost of caring." One participant summarized the whole group's feelings when she said, "what was most helpful was just having this group there; that it was available for us to talk through our issues and concerns. It was affirming and validating being able to actually name what was wrong with me. I learned a lot. Thank you (Participant eleven)." Another participant wrote, "It was comforting to learn that it was not just me. I'm not alone in this. I felt heard. I gained insight into what's going on with me. I was able to name my problem." Interestingly, where other measurements and questions yielded mix results, responses to this question seemed most unanimous. Everyone benefited from being in a support group like the context in which they were free to fully express and process their thoughts, concerns, and issues.

Finally, it may be recalled that this project set out from the start to answer three questions. First, are employees in Vitas' Cincinnati program at risk for compassion fatigue and burnout? Second, will increasing their awareness of it by educational programing be an effective strategy to help remedy it. Finally, how can such findings help the company as a whole?

Based on the results of this study, the answer to the first question seems obvious. The results of ProQOL-V and SCAW surveys suggest that employees in the Cincinnati program of Vitas Health are at risk, high risk for compassion fatigue or burnout. Further, while the pre and post survey results are too mixed to draw any definitive conclusions about the second question, participant reactions and engagement in the group processes suggest that participants did and are benefitting from the information shared. Question 10 on the exit interview asked participants what advice they would offer someone coming

into the field. Without exception all nine referenced some advice pertaining to the importance of self-care. The third question asked can such findings be helpful to Vitas. The answer was an unequivocal yes. These findings were presented to upper management at the conclusion of the six-week class. Four great changes came out of that meeting. First, I was asked to present my power point presentation to all of our employees at the next all-staff meeting, which they made mandatory. Second, we got approval and a budget to establish and furnish a meditation, counseling room for employees. Three, I was asked to develop a year-long curriculum of self-care to be implement during team meetings monthly. Fourth, I partnered with Aruni Maripane, the Buddhist chaplain to provide an ongoing support group for employees. There does in fact appear to be positive correlations between education and awareness, and awareness and positive actions in this case.

Conclusion

The guiding hypothesis for this dissertation project was that educating caregivers on best practices and techniques of providing self-care is an effective way to raise awareness of the importance thereof and is an effective diversion compassion fatigue and burnout. The literature review suggested that long term exposure to human suffering can be detrimental to caregivers. Thus, a primary objective of this project was to gain a better understanding of the causes and remedies to compassion fatigue and burnout as consequences to working with or being exposed to human trauma. The presupposition is that people who make it their life's work, mission, or ministry to care for others, need to

be cared for themselves, and failure to attain a healthy balanced lifestyle can constitute a kind of self, or in the case of employers, institutional abandonment.

From the synergy chapter (one), it may be recalled that issues of abandonment loom large in my own upbringing. This led to a whole lot of emotional, psychological, and spiritual pain and suffering on my part. Being the product of an unhealthy and abusive environment sensitized me to the needs and concerns of vulnerable and or neglected or hurting people. It tends to taint the way I view or engage the world. I have always had a strong desire to help others who may struggle with abandonment issues. This led me to look at what I perceive as potential abandonment issue in my current context Vitas Health where employer/employee relations were concerned.

This inquiry began in chapter two with an exegetical analysis of Jesus' cry of dereliction in Mark 15:34. Here, we see Jesus' human nature, the Son of Man, not His divine self, the Son of God, lamenting the horrors and atrocities of the cross. It was God's compassion, love, and empathy that motivated Him to act on behalf lost and hurting people. It was God's exposure to humanity's suffering under the weight of sin that brought Him to the cross. In the isolation and aloneness, in the darkness, and in the dying of the cross, Jesus' human nature let out a gut wrenching cry, "My God, My God, why hast Thou forsaken me?" This is a perfect example of the pain and anguish of abandonment; suffered not just on the cross but on the hearts and minds of all those courageous men and women since then who have dared to answer to call to render selfless service to hurting people.

In chapter three, we examined the historical narrative of canonized nineteenth century Roman Catholic Priest, Damien de Veuster, who left his home in Tremeloo

Belgium to become a missionary to a leper's colony on the Hawaiian Island of Kalaupapa. Here, he willingly practiced what Dietrich Bonhoeffer would later coin Kenosis or "emptying of oneself on behalf of others." He committed himself exclusively to providing compassionate care to the ravaged and dying lepers of the island. He identified with them in every way possible giving no concern to his own of exposure to contagion. It may be recalled from chapter two according Milsome, "He was their champion: he fought ceaselessly for their rights. He was their father and friend: he was totally available to help all their needs, from lifting broken spirits to bandaging leprous sores, from organizing musical and sporting events to making coffins and digging graves." Milsome pointed out that Damien was no social worker pretending to be a priest only trying to serve the spiritual and material needs of vulnerable people. All the while, his personal needs for collegiality, friendship, and someone to pray with were denied because of the government-imposed banishment. This eventually took its toll on Damien and started impacting his judgement and behaviors. He became increasingly cynical and oppositional especially the religious and business elites. It could be argued that this may have been a manifestation of compassion fatigue or burnout which he never got treatment for. Damien died from leprosy at the young age of forty-nine. Some clinicians refer to this at "the cost of caring."

In chapter four, we learned from Dietrich Bonhoeffer's theological framework that all who work in ministry or in compassionate care for others do have a special sense of call to it. For him, Christ is at the center of everything and that to be a Christian, the church or a servant literally requires self-abandonment for the Kingdom of God (Matt. 10:37, 16:24-25, and 1 Pet. 2:21). Bonhoeffer believed that Christians were called to

empty themselves before God in and through Christ Jesus in service to others; that God has a specific plan for all believers which requires complete submission via faith and obedience. This implies a willingness to meet real people where they are in the real world with a Christocentric motive of impacting their lives. This is the essence of compassionate care. This also aligns with Dr. Emma Sepala of Stanford University who describe compassion as "the emotional response to perceived suffering accompanied by an authentic desire to help."

Chapter five looked at the field of psychology to seek insight from psychologist Charles Figley's theory of compassion fatigue. Here we learned that compassion fatigue is a construct characterized deep physical and spiritual exhaustion accompanied by acute emotional pain. The consequences of which might have been evidenced in my own spiritual journey, in Jesus' cry of dereliction, in the lives of Father Damien de Veuster or Dietrich Bonhoeffer, among and those who serve in the helps industry. It was certainly evidenced among the participants of this dissertation project.

This project adopted three learning goals. First, participants gained insight and understanding into the nature and causes of compassion fatigue and burnout. Second, participants were able to personally identify with course material relevant to their own roles as hospice workers. Third, participants gained an increased awareness of the importance of maintaining good personal mental, emotional, social, and spiritual hygiene or self-care. The hypothesis of this project was that increased educational programming would increase awareness in participants concerning the importance of self-care. I further predicted that awareness would be evidenced by pre and post-class ProQOL-V and SCAW scores. Unfortunately, the results here were very mixed. On one hand, the

hypothesis was not supported the pre and post-class ProQOL-V and SCAW scores across all participants. Some participant's results confirmed the hypothesis others did not, but for the most part the data yielded was somewhat dubious. For example, the results for the ProQOL-V subscales while not supporting the hypothesis, nonetheless, yielded some very interesting data. On the compassion satisfaction subscale which measured job happiness, all participants scored around fifteen points lower than the national averages for this category. On the burnout subscale all of the participant scored double the national averages for this category. The same can be said about the results for the compassion fatigue subscale. The SCAW also yield pre-class than post-class scores (again refuting the hypothesis). While the SCAW has no established psychometric measurement standards, participants combined scores ranged from 62-79% of the tools highest possible scores. The results of these scales proved inclusive with regards to the hypothesis.

Based on lessons learned along the way, there were at least three possible explanation of the inconsistencies encountered with the results. First there, were extraordinary concurrent stressors occurring in the workplace. The latter portion of 2019 Vitas suffered massive turnovers across all disciplines meaning that those who remained had to endure many additional burdens in the interim. Half of our nurses, many CNAs three managers, and half of our psychosocial department left Vitas. A few of them retired, but most of them went to a competitor. When someone leaves our company to go to a competitor that usually results in an immediate termination of their relations with Vitas. They literally get "walked off the premise." This leaves an inevitable void in our program without the possibility of transition, or to even hire a replacement in a timely

fashion. Unfortunately, Cincinnati had a couple of smaller competitors who were aggressively recruiting Vitas staff because of our reputation and the widely noted caliber of our staff. They were offering significantly higher wages. Nurses and CNAs who remained had to bare the burden of increased patient care work-loads and longer hours. Psychosocial staff case-loads and territories doubled. In addition to these the company experienced a turnover in executive management, the fourth in the past seven years. In fact, the staff shortage is why I lost four of the original thirteen participants in my project. Stress level were "through the roof" because staff members were simply stretched too far. Those who did stay and participated in this project did so primarily because of their relationship and respect of me. This is most evident in the compassion satisfaction portion of the PROQol-V scale. Once more, compassion satisfaction suggests that one derives a sense of fulfillment or satisfaction with his/her work and/or workplace. While the pre and post scores did not support my hypothesis, the group as a whole were nearly twice lower than the national average of thirteen. Our pre-class average was twenty point five (20.5) and the post-class average was twenty respectively. This suggests that if Vitas does not do something to intervene, to offer better supports and assurances to their employees, there could very well be a continued "bleeding out" of staff.

Secondly, there may not have been enough time between acquiring new information and actually implementing it in one's daily life to get a fair or more accurate measurement on the pre and post scales. Five classes of actual educational instruction over a six-week period simply may have not been enough to see significant difference in the pre and post scores. This is especially true in-light of fact that for both the compassion fatigue and burnout sub-scales participants were twice as high as national

averages, while scoring poorly for job satisfaction. These coupled with the numerous current stressors can make processing, learning and acquiring new information difficult for anyone. It seems to me that there are at a couple of possible remedies to this problem Extending the class from one to one and a half hours may be helpful. That way participants have extra time to engage and process learned material. Further, allowing for eight instead of six weeks of classes, which allows participants more time to attempt to appropriate learned material. However, during these additional classes no further instruction takes place. The research should simply place one phone call per week to participants reminding to try the newly learned self-care strategies.

Third, with such low scores for satisfaction and high scores for fatigue and burnout, some participants may already exceed the need for awareness training. This meaning that they began this process already fatigued or burned out and in need of some kind therapeutic interventions. This was evident not only in the pre and post-class SCAW and PROQol-V scores but in class four where there was no lecture material presented. We simply allowed participants to reflect on the material presented in classes two and three which as it turns out, was a very revealing experience. Some participants became very expressive and emotional. People started sharing their personal stories and struggles relevant not just to hospice, but to life in general. The group encouraged one another onward. Tears started flowing, and people were hugging one another. A social worker who has been with Vitas for eighteen years commented, "I finally know what's wrong with me, I can name it." She talked about experiencing mood changes and irritability that were even impacting her home life. Another person said, I'm getting to the point where I don't like people anymore. Someone else commented, "It's good to

know that I'm not the only one, I'm not alone." Further evidence that these employees were probably beyond the need for increased awareness and probably needed clinical intervention was found in their answers to exit interview questions. Six of them identified depression as an issue. Five identified irritability, four insomnia, one guilt, and two intrusive thoughts as problematic. All but one participant identified multiple concurrent stress related psychological or emotional issues (See Table 7). Combined with these issues may explain why this the PROQol-V scale and the SCAW worksheet failed to confirm my hypothesis. People who are already stressed out do not need to be made aware of it; they need help.

Nonetheless, the information gained from the in-class interactions and exit interviews suggest that I was able to at least partially achieve our three learner goals of insight, personalization and awareness. Further, I sought to answer three questions at the start of this journey. One and two had to with education and awareness as addressed above. The third question asked how this information might be helpful to Vitas. Well, as it turns out, it has proven very helpful. This curriculum is already being implemented program wide in Cincinnati and the power point presentation presented in classes two and three is in the process of being accredited for national use as a continuing education marketing tool with Vitas. Moreover, we have gotten approval to establish a mediation room and an ongoing employee support group. This empirical evidence strongly supports the hypothesis that increased information raises the awareness of the need for effective self-care.

I am confident that this subject will continue to be of paramount importance in the fields of social science, humanities and religion. My recommendation for this type of

experiment moving forward is threefold. First, the class should be held in a quiet secluded place with the least amount of distraction as possible. Two, the class time should be extended from an hour to two hours or at least an hour and a half. This allows for the information to be absorbed, discussed, and processed better. Three, I would only offer meals or refreshments before or after the class, not during. Fourth, the process needs to be extended from six weeks to eight weeks. I believe that participants should have a least two weeks to sit with or try to apply the new information. However, during the final two weeks no class is held. Participants are only called and encouraged to think about the need for self-care or life-style changes as taught in class. They are then instructed schedule time to come in individually for post-class surveys and exit interviews. Fifth, if this is type of experiment is replicated for hospice personnel, I recommend doing it on the weekend with a larger sample size (including Continuous Care Staff). Six, to assure consistence and follow-though some kind of stipend may need to be considered.

Finally, this journey started with the church and my hopes are to take this kind of self-care awareness training back to the church. I am convinced that pastors and congregations struggling with self-care or abandonment will find its research, curriculum and guidance very helpful. I believe that far too many clergy and lay leaders are silently suffering with or at risk for compassion fatigue and burnout. Therefore, one of my goals is to convert this presentation into one more suitable for a religious context free from the constraints imposed on it in a secular setting.

APPENDIX A

CLASS SYLLABUS

Understanding and Remedying Compassion Fatigue and Burnout Among Hospice Workers

Instructor: Jerome Weaver jerome.weaver@vitas.com

(513) 742-6583 (Office) (513) 615-1592
(Cell)

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September 12, 2019

Thanks everyone for your willingness to be a part of this phenomenological research project. The goal of this study is to seek insight and understanding into the nature of compassion fatigue and burnout in end-of-life care. It is hoped that the study's findings could have wide scale implications and benefits for Vitas employees nation-wide. Below is an outline of what you can expect for the next six weeks. My contact information is listed above. If you have any questions or concerns over the next few weeks. Please feel free to contact me at any time by phone or email. Please try to make every class as your weekly attendance is very important to the project's success. However, if you need to miss a class, I will allow you to miss and make up one of them. Your participation means to the world to me. As a show of appreciation and for your convenience lunch will be provided at each class.

Week# 1 - September 12 – Consents, Introductions, Assessments and Q&A.

Week# 2 - September 19 – Lecture (Compassion Fatigue, Burnout, and Compassion Satisfaction).

Week# 3 - September 26 – Lecture Continued

Week# 4 - October 3 – Group Discussion on Subject Matter

Week# 5 - October 10 – Aruni Marepane (Buddhist Chaplain) – Self Care & Relaxation Techniques

Week# 6 - October 24 – Dr. Michelle Owens-Gary (Psychologist) – the Clinical Perspective of Self Care

APPENDIX B

CALLED TO CARE: ADDRESSING COMPASSION FATIGUE AMONG HOSPICE WORKERS

Called to Care: Addressing Compassion Fatigue Among Hospice Workers

Michelle D. Owens-Gary, PhD, MA
Behavioral Scientist
Centers for Disease Control and Prevention

Hospice Workers

- Caring for dying patients and their families
  - Fulfilling
  - Enriching
  - Meaningful experience
  - Calling in life
  - Yet, also can be stressful and overwhelming
  - How can hospice workers maintain a sense of balance in caring for patients and taking care of self?

Quote

- *"The expectation that we can be immersed in suff[illegible] and loss daily and not be touched by it is as unreali[illegible] as expecting to be able to walk through water witho[illegible] getting wet"*

  --Remen, 1996

Action Plan

- Just as hospice workers develop a plan of care for their patients
  - In an effort to prevent burnout, there is a need to develop a self-care plan
  - Balance needs of patients with one's own needs

Compassion Fatigue: What is it?

- Our main task as helpers is first to meet the physical/emotional needs of our clients
- While rewarding, this can also be stressful
- Compassion Fatigue
  - Costly: helpers, clients, organizations
  - Considered the "cost of caring" for others emotional/physical pain
  - Stress resulting from exposure to traumatic event(s)
  - Cumulative burnout

Compassion Fatigue

- Depleted ability to cope with one's everyday environment
- Trauma of helping others and listening to their different circumstances
- Can result in a change in helper's ability to feel empathy for their clients

Am I Experiencing Compassion Fatigue? The Symptoms

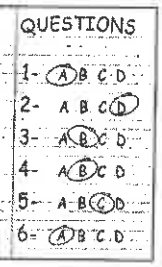
- Physical exhaustion
- Emotional exhaustion
- Irritability
- Changes in sleep pattern
- Weight loss/weight gain
- Headaches
- Loss of enjoyment of one's career
- Stress-related illnesses
- Depressive symptoms/depression

Compassion Fatigue: The Danger Zone

- Additional common warning signs include:
  - Increased use of alcohol/drugs
  - Dreading working with certain clients
  - Heightened anxiety or irrational fears
  - Difficulty separating work life from personal life
  - Absenteeism
  - Difficulty making decisions for self, clients
  - Interpersonal challenges

Self-Check: Compassion Fatigue/Satisfaction Test

- Take the test on your own
- www.isu.edu/~bhstamm/tests.htm
- Get support and help if needed!



Quick PSA: What is mental health?

- Mental health is a level of psychological well-being
- It's an absence of mental illness

What is Depression?

- Feeling sad or low
- Feeling more tired than usual/less energy
- Feeling upset at little things
- Difficulty thinking, making decisions
- Changes in appetite
- Changes in sleep pattern
- Feeling worthless/hopeless
- Having headaches, backaches, stomachaches
- Thoughts of hurting yourself or someone else

Depression: A component of Compassion Fatigue

- 16 million American adults experience depression [illegible] year
- 350 million adults worldwide develop depression [illegible]
- More women than men diagnosed with depression
- Average age is 32, yet young and older adults also [illegible]
- Good news! Depression can be treated!
- If you think you might be depressed, get help!

Get help!

- Pastoral counseling/support
- Therapy
- Trusted friend
- Medication
- BUT...STIGMA gets in the way!

Compassion Fatigue: Who is At Risk?

Compassion Fatigue: Who is At Risk?

- Everyone who care for clients/patients can experience varying amounts of compassion fatigue
- Study on nurses found that 20% of them had experienced mental health issues that made their workload difficult over a 30-day period (Statistics Canada, 2005)

Compassion Satisfaction

Compassion Satisfaction

- Protective mechanism against compassion fatigue
- Represents the fulfillment that we experience from helping others
- The positive benefits we experience in our work, with clients, with the organization
- Decreases stress and burnout
- Increases
  - Personal growth
  - Motivation and interest
  - Engagement with others/clients

Exercise. Write it Down. What is important to you in compassion satisfaction?

- What motivates you to do the work that you do?
- What do you think keeps workers satisfied in their helping roles?
- What challenges/barriers do you think organizations needs to address to increase satisfaction?

The Work Organization: Addressing Compassion Fatigue

What Can the Work Organization Do to Reduce Compassion Fatigue?

- Openly discuss and recognize compassion fatigue in the workplace
- Helpers can normalize compassion fatigue for each other
- Mutually define what is a supportive work environment
  - Is there proper opportunities for debriefing?
  - Do helpers feel safe sharing impact of work?
  - Are mental health days recommended/supported?
  - What does poor support look like? Is it established? Ad-hoc?
  - What professional development opportunities exist? What's

Personal Strategies: Addressing Compassion Fatigue

Self-care

- Cornerstone of compassion fatigue prevention
- Helpers tend to put themselves last
  - Feel guilty for taking time out for themselves
  - Ask yourself: Do I have a balance between nourishing and depleting activities in my life?
  - Are you de-stressing in positive or risky ways?

Self-care as hospice workers

- Hospice workers need to grieve
- Helper grief
  - Explore your personal experience with grief
  - How do you allow yourself to express these feelings
  - What helps you through the grief process?
  - Recognize when your personal grief experiences resurface (what triggers?)
    - Perhaps clients remind you of a loved one or their experience is similar to someone you know
  - Work through this with helps family, friends, professionals

Self-care as hospice workers

- Crying can be helpful, give self permission
- Find expressive ways to explore feelings
  - Writing
  - Drawing
  - Dancing

Self-care as Hospice Workers

- Introverted Vs. Extroverted workers
  - Introverted workers: need adequate time alone to reflect
  - Extroverted workers: need to verbally express their emotions

Self-care as Hospice Workers

- Take time alone
  - Silence
  - Meditation
  - Praying
  - Centering, balance

Self-care as Hospice Workers

- Play!
- What's fun for you?
  - Gardening
  - Reading
  - Cooking
  - Arts and crafts
  - Golf
  - Fishing
  - Trancing
  - Socializing
  - Humor

Exercise. Write it Down...Setting Boundaries

- What are boundaries?
- What boundaries do you need to separate your personal and professional life?
- What boundaries do you need to take care of yourself? To leave work at work?
- Where do you need to say "NO!" more??

What do I deserve...?

- A day away from everyone, everything
- A day of pampering
  - Dinner with friends
  - A fun outlet
  - Everyone out of the house!! Go!!
  - What else?

Exercise. Write it Down... What is it that you deserve?

- I deserve...

Exercise. Write it down...

- What gets in the way of you getting what you deserve? What you need?
- Do you need a break from anything?
- What takes up your free time?
  - Social media
  - Other distractions

Write it down...

- What are you hobbies?
- When was the last time that you did your hobbies?
- How can you leave more time in your life to do some of your favorite hobbies?

Compassion Fatigue: When Help is Needed

- As discussed, compassion fatigue can lead to mental health issues (depression, anxiety, suicidal thoughts)
- Talk to your health care providers about options (counseling, medication, both)
  - Can prevent relapse
  - Provide more coping skills

Compassion Fatigue: When Someone Close to Me Has It

- Show compassion
- Be kind
- Be supportive
- Allow them a space to talk
- Listen
- Ask how you can help

Resources

A delicate balance: Self-care for the hospice professional

http://www.tod[illegible]atricmedicine.com/archive/[illegible]38.shtml

Rejuvenating, refreshing tips to combat compassion fatigue

https://totaltriage.com/blog/hospice-administration/rejuvenating-refreshing-tips-combat-compassion-fatigue/

Questions?

APPENDIX C

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL) VERSION 5

PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

COMPASSION SATISFACTION AND COMPASSION FATIGUE
(PROQOL) VERSION 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some-questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been affected by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my job as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed because of the traumatic experiences of the people I *[help]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. I feel worn out because of my work as a *[helper]*.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed because my case [work] load seems endless.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very caring person.
_____ 30. I am happy that I chose to do this work.

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of Compassion Fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress _____

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other's trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. If your work puts you directly in the path of danger, for example, field work in a war or area of civil violence, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, for example, as a therapist or an emergency worker, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

WHAT IS MY SCORE AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

3. ____
6. ____
12. ____
16. ____
18. ____
20. ____
22. ____
24. ____
27. ____
30. ____

Total: ____

The sum of my Compassion Satisfaction questions is	So My Score Equals	And my Compassion Satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are "reverse scored." If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way though they can tell us more about their negative form. For example, question 1. "I am happy" tells us more about the effects of helping when you are *not* happy so you reverse the score

You Wrote	Change to
	5
2	4
3	3
4	2
5	1

*1. ____ = ____
*4. ____ = ____
8. ____
10. ____
*15. ____ = ____
*17. ____ = ____
19. ____
21. ____
26. ____
*29. ____ = ____

Total: ____

The sum of my Burnout Questions is	So my score equals	And my Burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Secondary Traumatic Stress Scale

Just like you did on Compassion Satisfaction, copy your rating on each of these questions on to this table and add them up. When you have added then up you can find your score on the table to the right.

2. ____
5. ____
7. ____
9. ____
11. ____
13. ____
14. ____
23. ____
25. ____
28. ____

Total: ____

The sum of my Secondary Trauma questions is	So My Score Equals	And my Secondary Traumatic Stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

APPENDIX D

SELF-CARE ASSESSMENT WORKSHEET

Self-Care Assessment Worksheet

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.[1]

Using the scale below, rate the following areas in terms of frequency:

5 = Frequently
4 = Occasionally
3 = Rarely
2 = Never
1 = It never occurred to me

Physical Self-Care

___ Eat regularly (e.g. breakfast, lunch and dinner)
___ Eat healthy
___ Exercise
___ Get regular medical care for prevention
___ Get medical care when needed
___ Take time off when needed
___ Get massages
___ Dance, swim, walk, run, play sports, sing, or do some other physical activity that is fun
___ Take time to be sexual—with yourself, with a partner
___ Get enough sleep
___ Wear clothes you like
___ Take vacations
___ Take day trips or mini-vacations
___ Make time away from telephones
___ Other:

Psychological Self-Care

___ Make time for self-reflection
___ Have your own personal psychotherapy
___ Write in a journal
___ Read literature that is unrelated to work
___ Do something at which you are not expert or in charge

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[1] Karen W. Saavitne et al., *Transforming the Pain: A Workbook on Vicarious Traumatization* (New York, NY: W. W. Norton and Company, 1996).

___ Decrease stress in your life

___ Let others know different aspects of you

___ Notice your inner experience—listen to your thoughts, judgments, beliefs, attitudes, and feelings

___ Engage your intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance

___ Practice receiving from others

___ Be curious

___ Say "no" to extra responsibilities sometimes

___ Other:

Emotional Self-Care

___ Spend time with others whose company you enjoy

___ Stay in contact with important people in your life

___ Give yourself affirmations, praise yourself

___ Love yourself

___ Re-read favorite books, re-view favorite movies

___ Identify comforting activities, objects, people, relationships, places and seek them out

___ Allow yourself to cry

___ Find things that make you laugh

___ Express your outrage in social action, letters and donations, marches, protests

___ Play with children

___ Other:

Spiritual Self-Care

___ Make time for reflection

___ Spend time with nature

___ Find a spiritual connection or community

___ Be open to inspiration

___ Cherish your optimism and hope

___ Be aware of nonmaterial aspects of life

___ Try at times not to be in charge or the expert

___ Be open to not knowing

___ Identify what in meaningful to you and notice its place in your life

___ Meditate
___ Pray
___ Sing
___ Spend time with children
___ Have experiences of awe
___ Contribute to causes in which you believe
___ Read inspirational literature (talks, music, etc.)
___ Other:

Workplace or Professional Self-Care

___ Take a break during the workday (e.g. lunch)
___ Take time to chat with co-workers
___ Make quiet time to complete tasks
___ Identify projects or tasks that are exciting and rewarding
___ Set limits with your clients and colleagues
___ Balance your caseload so that no one day or part of a day is "too much"
___ Arrange your work space so it is comfortable and comforting
___ Get regular supervision or consultation
___ Negotiate for your needs (benefits, pay raise)
___ Have a peer support group
___ Develop a non-trauma area of professional interest
___ Other:

Balance

___ Strive for balance within your work-life and workday
___ Strive for balance among work, family, relationships, play and rest

APPENDIX E

POST-CLASS INTERVIEW QUESTIONS

Understanding and Remedying Compassion Fatigue and Burnout Among Hospice Workers

Instructor: Jerome Weaver jerome.weaver@vitas.com

(513) 742-6583 (Office) (513) 615-1592 (Cell)

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October 24, 2019

Interview Questions

Participant #_____

1. How many years have you worked in hospice and palliative care?

2. Describe how you cope with ongoing patient deaths and the families following these death.

3. Professional compassion fatigue is described as having the potential of causing negative effects for those who continually care for patients who are seriously ill, wounded, traumatized and the dying.

    a. What are your thoughts about this

    b. Do you have any feelings around this concept?

   c. Have you ever experienced any distressing symptoms related to this work (nightmares, difficulty sleeping, intrusive thoughts, depression, etc.)?

4. Has your view of death changed since you began this work?

5. When you return from vacation, do you feel refreshed or rejuvenated?

6. How would you know if you needed a break from hospice or palliative care?

7. Describe what coping strategies were before this workshop.

8. What role does your manager or company play in supporting you in this area of practice?

   a. Do you feel supported by your manager/employer

9. Describe what you found most helpful about this course

10. Do you have any recommendations for other hospice employees which might enable them to continue in this field over a long period of time?

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